Service Array Index

A. Access and Visitation Grant Funds

Federal Access and Visitation Grant funds provided to Kentucky are under the jurisdiction of the federal Office of Child Support Enforcement and are geared toward facilitating access and visitation of non-custodial parents who are experiencing difficulty in seeing their children due to issues such as poor relationships with the custodial parent, non-payment of child support, or allegations of domestic violence. In June 2016, the grant transferred from the Department for Community Based Services (DCBS/department) to the Department for Income Support's Child Support Enforcement (CSE) program. CSE decided to collaborate with the Louisville Legal Aid Society (LAS) to establish an Access and Visitation Hotline in an effort to educate parents in all 120 Kentucky counties about access to and visitation with their children. A memorandum of agreement with LAS began on January 20, 2017. In April 2017, the hotline went live. Once operational, publicizing of the hotline occurred through public service announcements, print, media, press releases, and the addition of hotline information to both the CSE and LAS websites. LAS hired an attorney who is responsible for handling calls received on the hotline. Callers go through an intake process to ensure they meet the guidelines to receive services through LAS. The attorney captures the following data in the intake database: gender, race, age, reason for calling, and participation in an IV-D case. Race codes were revised to mirror the federal race codes and include *American Indian or Alaskan*, *Asian*, *Black or African American*, *Hispanic or Latino*, *Native Hawaiian or Pacific Islander*, *White*, *Two or More Races*, *Data Not Reported*, and *Other*. If necessary, callers are referred to a partnering legal aid program located in the geographical area where the caller resides. Staff in CSE then receives the above data in addition to data regarding how the hotline served the caller. Through the end of December 2018, 803 persons have contacted the hotline for assistance related to access to and visitation with their child(ren). Child support paid LAS $121,184.75 in calendar year 2018. At this time, there are no perceived barriers with the Access and Visitation Hotline or the partnership with LAS.

B. Batterer Intervention Certification Program

On January 1, 2018, the Batterer Intervention Certification Program was moved from the department to the Kentucky Coalition Against Domestic Violence (KCADV). KCADV now administers the state's Batterer Intervention Certification Program by enrolling providers, conducting training, monitoring providers, and maintaining the provider list. KCADV also responds to complaints regarding batterer intervention providers. There is at least one certified Batterer Intervention Provider offering services in 57 counties of the Commonwealth. In general, the unserved counties correspond with counties that are underserved in many other service areas (in the far Eastern, Western, and Southeastern parts of the state).

Batterer intervention services are not specifically funded through any state or federal grant. Services are provided to those court ordered to attend or compelled by probation/parole or DCBS; however, there is variability in court, probation/parole, and DCBS referral practice across the state. In many of the unserved counties, judicial practice does not include mandating domestic violence offenders into batterer intervention programs. In counties that are economically disadvantaged, the absence of public funds to subsidize or offset the cost to individuals further exacerbates the issues around recruiting and retaining batterer intervention providers/programs in specific locations. However, a list of batterer intervention providers and the cities they serve is found on the KCADV website and is shared with the Cabinet for Health and Family Services (CHFS/cabinet) and the Administrative Office of the Courts. The directory of providers is located at https://members.kdva.org and updated at least weekly.

Certified providers provide individualized treatment and have the capacity to include issues relevant to children exposed to domestic violence, parenting after violence, and shaken baby syndrome/abusive

head trauma. Certified providers also assess for possible substance use and mental health issues. In 2018, four certification training events were held to certify new batterer intervention providers. Approximately 80 people were trained and 30 were certified to become batterer intervention providers.

New initiatives in support of the batterer intervention provider program include the following:

- Development of new products in support of program standards such as a brochure detailing the program for victims, a partner contact guide, a comparison chart for anger management and batterer intervention providers, and a handout for judges to encourage additional referrals;
- New training offerings that include Caring Dads, Emerge training, review of batterer intervention provider regulations, and best practices for assessment and victim contact;
- Needs assessment of batterer intervention provider providers in Kentucky;
- Regulations review and update;
- Investment in batterer intervention provider-centered resources (curricula, workbooks, videos, etc.);
- Development of an annual pre-conference for batterer intervention providers;
- Development of a support team that includes four coalition staff; and
- Integration of batterer intervention providers into the KCADV training faculty.

Please note that the data included in the below table reflects state fiscal year 2018 (July 1, 2017 through June 30, 2018). KCADV will adjust the reporting period for providers and will provide data for calendar year 2019 in 2020.

Batterer Intervention Program Data: State Fiscal Year 2018			
Category	**Male**	**Female**	**Total**
Batterers Assessed*	2123	347	2470
Civil/DVO Referral	997	126	1123
Criminal/Post Conviction	1047	142	1189
Diversion	443	36	479
DCBS Referral	226	72	298
Self-Referred	106	51	157
**Referral sources are not exclusive categories and a single batterer may be referred by more than one referral source.*			

C. Child Victims' Trust Fund Board

In 1984, the passage of House Bill 486 established the Kentucky Child Sexual Abuse and Exploitation Prevention Board (CSAEP Board) and the Child Victims' Trust Fund (CVTF). The CSAEP Board is an autonomous body within the Office of the Attorney General and exists as the sole organization in Kentucky with the statewide mission to prevent child sexual abuse. The organizational structure and duties of the CSAEP Board are set forth in Kentucky Revised Statute (KRS) 15.900 to 15.940. Since its inception, the CSAEP Board has worked tirelessly to support high-quality prevention programs across the Commonwealth. Assistance for programs has taken many forms, most notably financial support for prevention projects. Grants funded through the CVTF have been awarded to community and professional organizations throughout Kentucky, with technical assistance and operation oversight provided to the recipients. The CSAEP Board is increasingly aware of the need for funding prevention programs that engage in community education and enhance public awareness. The CSAEP Board also supports the regional Children's Advocacy Centers (CACs) throughout the Commonwealth by providing

supplemental funding for child sexual abuse medical examinations. The mission of the CSAEP Board is to help provide for the safety of Kentucky's children by preventing child sexual abuse and exploitation through educating the public, funding innovative programs, and shaping public policy. The CVTF provides funding for regional and statewide prevention programs and reimbursement associated with the costs of medical examinations at CACs. The CVTF also provides for the education of professionals at conferences.

Regional Prevention Grants

Fiscal year 2019 – awarded $72,640 to the following agencies:

- Child Watch Advocacy Center
    - Funding will provide training to more than 12,000 children in the western region of the state and approximately 300 children attending the Boys and Girls Ranch.
        - The "Safety Tools and Golden Rules" training serves Ballard, Caldwell, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, Marshall, and McCracken Counties, as well as the campers of the Kentucky Sheriffs' Boys and Girls Ranch.
        - The curriculum delivers sexual abuse prevention education to preschool and elementary school aged children in schools. Primary topics discussed are body safety, abuse prevention, and internet safety.
- Family Nurturing Center
    - Funding will provide 225 Stewards of Children trainings in the Northern region of the state to 3,000 adults.
        - The "Stewards of Children" training model serves Boone, Campbell, Grant, and Kenton Counties.
        - The training promotes core competencies in the areas of prevention strategies, recognizing the signs of sexual abuse, reporting requirements and responding appropriately to disclosures. The training also includes a unique motivational component that directly addresses reluctance to report and the necessity of shared adult responsibility for every child.

Statewide Prevention Grants

Fiscal year 2019 – awarded $32,635 to the following agency:

- Prevent Child Abuse Kentucky – "Reinventing Our Message: Promoting Action and Prevention"
    - This project, building upon increased awareness created by the CSAEP board's efforts, will enhance capacity to create a research informed messaging platform designed to change social norms and practices in the Commonwealth, achieved through the development of a messaging toolkit for distribution to, and utilization by, statewide partners. The resulting product, an action-oriented, sustainable messaging platform, will be made available to partners through social media, webinars, conferences, and other venues.

Statewide Public Education and Awareness

During fiscal year 2018, the board awarded $80,000 to Mike Pistorino's "Listen While I Color" program. Despite the board's efforts, partnerships were unable to be secured in order to have sufficient funding for full implementation. Other concerns were also presented, and the board ultimately voted to withdraw the program from the board's initiatives.

Child Sexual Abuse Medical Reimbursement Program

The CSAEPB board assists state designated CACs by assisting with the administrative costs of the specialized child abuse medical examinations. The board's funding provides $75 per child medical examination. Medicaid does not reimburse the CACs at the full amount, thus the local CACs are also responsible for seeking other funding sources. Additionally, CACs provide prevention education to child victims during their assessments and evaluations.

In fiscal year 2019, the CVTF awarded $78,075 to assist with the cost of approximately 1,041 specialized child sexual abuse examinations in 15 CACs across the state. Additionally, several conference sponsorships were awarded throughout 2018, which educate professionals about child sexual abuse and exploitation prevention. The board also sponsored three other child abuse conferences and provided $5,000 to the Kentucky Multidisciplinary Commission on Child Sexual Abuse.

During fiscal year 2019, the board awarded medical reimbursement grants to 15 CACs throughout the state. Additional grants were awarded for the focus of prevention of child sexual abuse and exploitation to one statewide and two regional programs.

The CSAEPB board has made good progress and continues to meet its mission. The board recognizes its responsibility of continuing to fund quality prevention programs with CSAEPB monies and to continue to provide funding to the CACs to assist with the administrative costs associated with the child sexual abuse medical examinations conducted at the centers. The board will continue to award grant applications each year in order to meet its mission in serving child victims of sexual abuse and exploitation as well as prevention efforts.

D. Children's Advocacy Centers

In 1998, Kentucky adopted a statewide CAC network, which provides for one CAC in each of Kentucky's 15 Area Development Districts. This "regional CAC model" ensures that children in every geographic area of Kentucky have access to a CAC. The state model provides a core set of standards set forth in KRS 620.020 and 922 Kentucky Administrative Regulation (KAR) 001:580 and modeled after the standards developed by the National Children's Alliance. These standards require Kentucky CACs to provide (either directly or as part of a collaborative memorandum of understanding) the following services: forensic interviews, mental health services, specialized child abuse medical exams, advocacy, court preparation, professional training, and community education programming.

Central to the CAC model is the simple, yet powerful, concept of coordination between community agencies and professionals. This coordinated response to child abuse cases is known as a multidisciplinary team (MDT). CACs, along with the other partner agencies, promote timely and effective systemic responses to child abuse by reviewing investigations, coordinating service delivery, and reaching the appropriate disposition of cases in the criminal justice system. The goals of MDTs in Kentucky, as outlined by the Kentucky Commission on Child Sexual Abuse, include (1) the safety and protection for child victims of sexual abuse, and (2) accountability of the child sexual abuse service system.

The state provides a critical base of funding that is roughly half of the total amount needed to operate the CAC network in Kentucky. As private, independent non-profit organizations, CACs receive additional funding from grants, individuals, and corporate funding opportunities. CACs are also eligible to receive Medicaid reimbursements for medical exams performed onsite and pursuant to 907 KAR 3.160. CACs also receive $75 for the case management services associated with child abuse medical exams from the CVTF.

Children's Advocacy Center Data Calendar Year 2018	
Service Category	**Number of Services Provided/ Persons Served**
New Children Served	8,747
New Caretakers Served	7,448
Advocacy Services: court, case management, referrals to services	57,092
Medical Services: comprehensive forensic medical exam, general exam, follow up exams, referrals for further medical treatment	791
Forensic Services: Forensic Interviews by CAC staff, Forensic Interviews Hosted by the CAC for trained child welfare interviewers	5,696
Mental Health Services: Individual, Family and Group treatment, Mental Health Screening	10,822
New Children Staffed by Kentucky MDTs	5,885
Total CAC Cases seen through Kentucky's MDTs in 2016	17,243
Training Programs Conducted	547
Community Partners Trained	16,319
Community Awareness Events	272

The CACs of Kentucky, a state association, offers an outcome measurement system to CACs. This system allows CACs and the state association to evaluate the quality of services. During 2018, CACs collected responses from over 1,200 caregivers and investigative partners. An analysis of these surveys found that 99.7% of caregivers describe CAC staff as friendly and pleasant while 95.2% of community partners report CACs provide resources that enable them to better work their cases.

The number of new children referred for services at a CAC continues to rise. CACs served nearly 2,000 more children during 2018 as compared to the prior year. Much of this increase is because CACs are serving a larger number of physical abuse cases. Although CACs were originally designed to respond to child sexual abuse cases, there is now widespread respect for the model as it relates to all forms of child abuse.

E. Child Care

The mission of DCBS' Division of Child Care (DCC) is to provide leadership in building high quality, community-based access to childcare and early learning that enhances health, safety, permanency, well-being, and self-sufficiency for Kentucky's children and families.

DCC strives to fulfill their mission through the following goals:

- Increase available quality child care that is developmentally appropriate, affordable, healthy, and safe;
- Provide access to early care and education, and provide support to early care professionals throughout the state;
- Engage families and community partners in collaborative decision making for early care and education;
- Provide safe child care services which support stability and self-sufficiency of families;
- Utilize technological resources to promote the improvement of outcomes in child care; and

- Expand data collection and management systems that allow for evidence-based management decisions.

The Child Care and Development Fund (CCDF) is the principal source of federal funding for DCC initiatives that maintain health and safety standards and improve child quality in childcare settings. Direct Temporary Assistance for Needy Families (TANF) dollars are used to fund Child Care Assistance Program (CCAP) benefits on behalf of individuals who receive public assistance. In addition, state general funds and tobacco settlement dollars are combined with CCDF dollars to fund CCAP, childcare quality initiatives, fitness determinations (background checks), and early care and education professional development. In order to ensure continuation of a program of childcare services, the cabinet must renew the CCDF State Plan every two years. The cabinet currently operates under the provisions established in the CCDF Plan for federal fiscal years 2019-2021 submitted December 21, 2018.

DCC is directly responsible for oversight of CCAP, the tiered quality rating and improvement system, childcare provider professional development, and childcare fitness determinations in all of Kentucky's counties. Childcare technical assistance, recruitment, referrals, and licensing are also responsibilities of DCC for the entire state. These programs are contracted to state and community partners and are supported by the Benefind assistance and support program online portal.

DCC has several mechanisms in place to support collaboration across service programs, which include internal departments within cabinet programs. Additional service provider collaboration through meetings and workgroups include but are not limited to The Governor's Office of Early Childhood, Kentucky Department of Education (KDE), Kentucky Head Start Collaborative, Division of Mental Health, and Department for Public Health, along with advocacy groups, including the Kentucky Partnership for Families and Children and the Prichard Committee for Academic Excellence.

DCC contracts with the Human Development Institute at the University of Kentucky for Child Care Aware Network of Services. Services provided include technical assistance to increase quality in early childcare and education facilities and access to high quality licensed type I and type II certified and registered providers throughout the state.

DCC manages CCAP. Children are eligible for childcare subsidies if the child has a current protection or prevention case or is in the care of fictive kin. DCC has made recent regulatory changes to allow CCAP funds to support childcare expenses for children in foster care.

On April 13, 2018, DCC filed regulation 922 KAR 2:270 *Kentucky All STARS quality based graduated early childhood rating system for licensed child care centers and certified family child care homes*. The emergency regulation repealed the state's previous quality rating and improvement system, STARS for KIDS NOW, and replaced it with the new, tiered quality rating and improvement system: Kentucky All STARS. In support of Kentucky All STARS, DCC introduced a new online system that allows providers to submit All STARS forms, track submissions, and view correspondence from DCC. The All STARS provider portal is integrated with the Kentucky Integrated Child Care System, which serves as a clearinghouse for provider licensure and quality rating data. The All STARS portal went live in June 2018.

In early 2018, Kentucky was awarded an additional 42 million dollars of discretionary funds through the Child Care Development Block Grant. The Administration for Children and Families requires that funds be obligated by September 30, 2019 and liquidated by September 30, 2020. To obligate the discretionary funds, emergency administrative regulation 922 KAR 2:160E was filed on November 30,

2018. The regulation was effective immediately and included a CCAP maximum payment rate increase for any county currently receiving less than the 40th percentile of the market rate. The regulation also immediately raised the discontinuance of childcare services at redetermination to 200% of the federal poverty limit and allowed for funding of childcare for foster children from CCDF funds. In addition, the regulation will allow full-time students to be eligible for childcare effective June 28, 2019.

The National Background Check Program was launched in March 2018. It is essentially a "one-stop shop" for providers to complete all required background checks. All child care staff members were required to have their background checks completed by the new system no later than September 30, 2018 in accordance with 922 KAR 2:280.

During state fiscal year 2018, an average of 30,999 children and 16,947 families received CCAP benefits. Of the total number of children receiving benefits, an average of 6,840 children were served as the result of a need for protective or preventive services. Children served as the result of protective or preventive services referrals were placed in safe and healthy environments supporting family unification. The total CCAP expenditures for state fiscal year 2018 were $118,267,815.

DCC contracts with the Kentucky Partnership for Early Childhood Services, housed at the University of Kentucky Human Development Institute, to provide coordination and administration of statewide Kentucky Child Care Resource and Referral (CCR&R) network services. To ensure adequate supply of quality child care programs and services are available in each regional hub covering the Area Development District, the services provided through the CCR&R regional network include the following: eight Regional Child Care Administrators, five Content Area Coordinators, one Technical Assistance Specialist Health/Safety, four Technical Assistance Quality Rating and Improvement System Specialists, 24 Quality Coaches, four Technical Assistance Health/Safety Coaches, four Training Coaches, and 13 Professional Development Coaches. Through its CCR&R contract, DCC works actively to meet the needs of families, provide referral information to families seeking childcare, increase family knowledge of the characteristics of high quality early care and education services, and increase provider access to training and professional development opportunities.

DCC receives consultation and technical assistance upon request to Administration for Children and Families-Region IV office and contracted affiliates.

Childcare report data collected through the Kentucky Integrated Child Care System assistance program is available to all 120 Kentucky counties. Data reports compiled quarterly, annually, and ad hoc are available for state and federal reporting. Analysis of data reports supports decision making as well as legislative, regulatory, and program improvements.

Effective October 1, 2017, the childcare application for eligibility determination transitioned to Benefind. This transition allows Kentucky's families to easily access public assistance benefits and information 24/7 through an online application and account. The goal of Kentucky's public assistance programs is to build strong families and obtain services such as food, cash, and medical assistance to become self-sufficient. Benefind is also a referral tool that used by parents in selecting quality childcare.

In 2018, DCC started work with the Kentucky Center for Statistics to improve the Early Childhood Profile, which is a cross-agency overview of early childhood education in the state. DCC worked to ensure that accurate and complete information was shared with the Kentucky Center for Statistics from all data management partners and that data represented in the report was accurate and easy to interpret. The

new and improved report will assist policymakers, practitioners, and the public to make educational and policy decisions.

During state fiscal year 2018, CCAP has experienced over a 23% increase in child enrollment. The number of families served has increased by more than 20% and the program has continued to sustain this without implementing a freeze in enrollment. This is likely due to the transition of CCAP to Benefind, which allows more Kentucky families easier accessibility to multiple public assistance programs such as childcare, Medicaid, and the Supplemental Nutrition Assistance Program.

DCC has made recent regulatory changes to support the funding of childcare expenses for foster children using Child Care Development Block Grant funds. Staff from DCC, the Division of Protection and Permanency (DPP), the Division of Family Support, and the Office of Administration and Technology are working to implement process, policy, and systems changes to effectively implement this change.

F. Children's Justice Act Grant

The Children's Justice Act (CJA) grants are provided to assist states in developing, establishing, and operating programs designed to improve the following:

1) The assessment and investigation of suspected abuse and neglect cases, including sexual abuse cases, in a manner that limits additional trauma to the child and child's family;
2) The assessment and investigation of cases of suspected child abuse-related fatalities and suspected child neglect-related fatalities;
3) The investigation and prosecution of cases of child abuse and neglect, including sexual abuse; and
4) The assessment and investigation of cases involving children with disabilities or serious health-related problems who are suspected victims of child abuse or neglect.

The CJA grant is comprised of federal funds. The services and programs funded by the CJA are operating and available in various locations throughout the state.

The CJA task force has implemented a new grant application process this federal fiscal year and grants are awarded after being reviewed and voted upon by the task force. Proposals are required to provide a plan for self-evaluation and thorough reporting prior to the release of funds.

The CJA task force sought consultation with Administration for Children and Families during 2018 through regularly scheduled conference calls.

CJA continued to fund pediatric forensic medical consultations for DCBS field staff. The task force has allocated $82,500 annually to assist in determinations of abuse and neglect, as well as provide expert testimony as needed. This is a critical service to field staff, as many communities do not have forensically qualified medical personnel.

The CJA has implemented a grant award system from a pool of applicants who have developed proposals according grant program instructions. Application instructions clearly outline CJA mandates as well as intended purpose and approved activities. Due to contact issues, two years' worth of grant activities will be implemented this fiscal year.

The CJA task force initiated and recruited training for medical professionals on human trafficking in the higher populated areas where major highways intersect. Emergency room staff will be trained to

identify victims and report and train co-workers upon completion of the course. This training will cover the entire state of Kentucky. This training continues to be implemented across the commonwealth.

Each program the task force funds is required to complete data collection after trainings to capture participants' level of knowledge. The task force has set the standard that any grantees must self-evaluate and provide that data to the task force when completed.

The task force is currently meeting to discuss how future projects can help minimize disruptions to children and families during investigations as well as the adjudication of allegations.

G. Children's Review Program

The Children's Review Program (CRP) is a program of Bluegrass.org, Inc. and performs its functions under a contract between Bluegrass and DCBS. The mission of CRP is to support DCBS in its efforts to assure the safety, permanency, and well-being of DCBS-committed children who are placed in out-of-home care (OOHC). CRP assigns levels of care to children in OOHC; provides direct assistance to DCBS Workers in locating, facilitating, and maintaining placements; and collects, analyzes, and interprets data related to placements and children's outcomes as part of its quality monitoring and assurance responsibilities. CRP maintains a database, which includes children's placement history, level history, diagnosis and psychotropic medication history, intelligence quotient when available, and other child specific information. CRP provides services to each county of the commonwealth through CRP staff who are located in DCBS offices across the state and at the statewide CRP office in Lexington. CRP is funded through Title IV-E and state general funds.

CRP has three primary functions: assessment, placement, and quality assurance, all of which work toward assuring the safety, permanency, and well-being of DCBS-committed children who are placed in OOHC.

As part of the assessment function, clinical reviewers assigned 13,522 levels (2938 initials, 8287 utilization reviews, 1237 redeterminations, and 1060 reassignments) during calendar year 2018.

As part of the placement function, regional placement coordinators assisted in or were involved with 5055 placements and made 369,604 referrals. Statewide placement office personnel facilitated or were involved in over 760 conference calls during 2018 (see additional details below).

As part of the quality assurance function, CRP maintained data on 10,801 children committed to DCBS at some point in 2018 and program information on 190 private child caring (PCC) and private child placing (PCP) programs that operated in 2018. This information is continuously being updated on an ongoing and as needed basis. In addition, during 2018, clinical reviewers identified 3913 quality improvement issues related to the services provided to children while in OOHC.

CRP's functions are directed by the contract with DCBS and through ongoing contact with DCBS at many levels throughout the year. This includes monthly meetings with central office staff including the director and/or assistant directors of DPP and other central office staff. There are also weekly phone conferences between CRP placement staff and DCBS central office staff to discuss difficult-to place children. In addition, CRP maintains ongoing communication with DCBS central office staff between meetings. CRP participates in committees and meetings as invited by DCBS. In the last year, this has included but not been limited to meetings involving the managed care organizations (MCOs), PCC/PCP providers, Project SAFESPACE (Screening and Assessment For Enhanced Service Provision to All Children

Everyday), the Building Bridges Initiative, the Child and Family Services Plan Continuous Quality Improvement Stakeholders, and the House Bill 1 Study Group. CRP staff participates in utilization review committees in selected regions. CRP's regional placement coordinators are co-located with DCBS staff throughout the state. CRP also has designated staff who work closely with the DCBS Medical Support Team to assure that all medically complex children are identified and tracked appropriately and that level assignments are as accurate as possible based on both the child's medical needs and other issues/behaviors. In the Southern Bluegrass and Northern Bluegrass Service Regions, CRP is involved in ongoing collaborative meetings between DCBS and PCC/PCP staff. A CRP staff person is actively involved in reviewing applications from programs applying to obtain a PCC/PCP agreement with DCBS.

In addition, CRP works closely with the PCC and PCP agencies individually and through their association, the Children's Alliance of Kentucky, to improve outcomes for children in the custody of DCBS. A joint bimonthly Quality Outcomes for Children Council meeting provides an opportunity to plan and track joint quality improvement activities. CRP representatives also regularly attend the Alliance's OOHC Council and Private Residential Treatment Facility Council meetings as community partners. CRP staff also work collaboratively with the private provider community to update Comparative Reports on a quarterly basis. This includes frequent email and telephone contact with providers around the state as part of CRP's effort to encourage accurate reporting of the data contained in these reports. Each program's Comparative Report provides information on program criteria, characteristics, and services that may be used in helping determine the most appropriate placement for a child. CRP is in frequent communication with the PCCs/PCPs for issues of data collection, level assignment, placement, and general consultation. For PCC/PCP programs that have questions, are new to the state, or have new leadership, CRP will provide information regarding the expectations of the programs as they relate to CRP. CRP conducted one CRP orientation meeting for a new program in 2018 and provided phone consultations to existing programs on an ongoing basis.

CRP posts detailed instructions on the CRP website for completion of the application for level of care payment, which is completed by providers at regular intervals regarding the behaviors and progress of children in their care. CRP also provides tips and guidance to programs on how to most accurately complete the application for level of care payment during the quarterly PCC Collaborative meeting in the Southern Bluegrass Service Region. CRP staff call programs about specific issues related to the completion of the application for level of care payment to improve a program's accurate reporting on this form. In addition, when making referrals, regional placement coordinators receive packets from DCBS workers to forward to potential placements. If the referral packets are incomplete or are missing important information, the regional placement coordinator will communicate with the DCBS worker to get a more complete packet of information. The regional placement coordinator also completes a cover sheet, which supplements the packet provided by DCBS, and summarizes the child's issues and needs.

Because CRP coordinates placements for children in DCBS custody, including children in psychiatric hospitals, it is important that CRP staff maintain relationships with psychiatric hospitals and MCOs. CRP tracks children in psychiatric hospitals through a census report generated by CRP and updated and returned to CRP by the hospitals on a weekly basis. In addition, CRP continues to supplement the census report by obtaining information from the hospitals and MCOs on an ongoing basis to be proactive in placement efforts with the goal of beginning discharge planning at the time of admission.

CRP is involved in efforts focusing on improving the coordination of care with multiple government entities, providers, and consumers of DCBS services. In addition to other activities listed in this report, CRP is also involved with the Kentucky Partners for Youth Transition group and a Statewide Interagency

Trauma-Informed Care Steering Committee coordinated by the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). CRP staff have also been actively involved in the Building Bridges Initiative being spearheaded by the DCBS Commissioner's Office.

CRP provides consultation and assistance on an as needed basis for a range of DCBS initiatives. Consultative efforts draw on the wide range of clinical expertise among the staff of CRP including assistance with service planning for children with severe emotional disabilities and for those with intellectual and developmental disabilities. In 2018, these efforts continued to include meeting with DCBS staff and providing data and feedback on child-specific and program-level quality improvement issues that were noted during utilization reviews. In addition, quality improvement information is made available to each PCC/PCP agency. CRP continues to revise quality improvement categories as needed to address DCBS concerns related to children in care.

Also during 2018, CRP continued to work with DCBS on 5S (specialized services) programs for children with high intensity needs. CRP facilitates conference calls on referrals and placements for children in these programs and, at the request of DCBS, reviews records of children in these programs in order to report to DCBS how well the programs are providing the expected services. CRP staff have also worked with DCBS staff in the implementation and ongoing assessment of some PCC and PCP pilot programs (e.g., Home of the Innocents CATS Program, Key Assets).

As mentioned previously, CRP routinely convenes telephone conference calls to discuss and address difficult placements, for decision making on locating placements that best meet the needs of DCBS children, and for clinical consultation. Calls are also convened to monitor out-of-state placements in order to thoughtfully plan a child's return to Kentucky and regular calls occur to support the new placement once the child returns. These conference calls may involve CRP and DCBS staff along with representatives of state guardianship; Protection and Advocacy; DBHDID; private providers, school and education personnel; MCOs; and families.

In 2018, CRP completed data requests for DCBS (e.g., supports for community living difficult-to-place contact information, Eastern Mountain Private Foster Parents and Children, first quarter 2018 private placements) as well as for the Children's Alliance and multiple providers.

In 2018, CRP continued to work to improve a Private Care Capacity and Occupancy Dashboard, which provides information to DCBS about the capacity and occupancy of private agencies throughout the state and presents the data in a more user-friendly format.

For the past several years, CRP has also worked with the University of Kentucky to serve as an internship site for undergraduate psychology students during the fall and spring semesters.

The current annual budget for CRP is $2,266,949.

During 2018, CRP continued to work closely to address needed changes and protocols related to the SAFESPACE initiative. SAFESPACE is a cooperative agreement between the DCBS, DBHDID, the University of Louisville, and several other interested parties to redesign the behavioral health service delivery system for children in OOHC. SAFESPACE was fully implemented during 2018, and the grant funding ended. During the early part of 2018, CRP staff had regular contact with Project SAFESPACE staff to address issues related to SAFESPACE implementation, but these contacts decreased as full implementation approached. This complex project had significant impact on CRP and CRP processes.

CRP continued to work with regional staff as to implement SAFESPACE processes for the remainder of the year. In addition, due to changes related to SAFESPACE, the use of the Child Behavior Checklist was phased out over the last couple of years and completely discontinued in 2018. In 2018, CRP continued to work closely with DCBS to evaluate a list of alternative tools that could be used for level assignment. CRP rated those tools for one year to determine their effectiveness for level assignment. This information was provided to the cabinet and no changes to the original list were made based on the findings.

Assessment:
CRP assigns levels of care to children as they enter PCC/PCP agencies and as the children progress through the system. Levels are assigned by clinical staff based on definitions provided in 922 KAR 1:360 (PCC placement, levels of care, and payment). Information used in the level assignments is provided by the DCBS worker, the PCC or PCP, or through other sources. These levels represent the treatment and service needs of the child. The numbers of level assignments over the past six years are as follows:

Fiscal Year	Total Reviews	Initials	Utilization Reviews	Redeterminations	Reassignments
2018	13,522	2938	8287	1237	1060
2017	12,495	2550	7948	978	1019
2016	12,342	2421	7687	1070	1164
2015	12,085	2443	7498	1141	1003
2014	12,031	2547	7422	1118	944
2013	11,084	2229	7054	953	848
2012	10,542	2096	6595	961	890

For the last six years, the number of level assignments has increased each year and by approximately 28% overall.

Staff who assign levels of care are required to maintain acceptable levels of inter-rater reliability, which measures the extent of agreement among reviewers when assigning levels. CRP is required to maintain an average inter-rater reliability of .50 (half a level from the mean) or less. In fiscal year 2018, CRP's inter-rater reliability was .11.

During the last year, CRP has continued to work to collect intelligence quotient scores on children, especially those children who have been described as low functioning or developmentally delayed by DCBS or placement staff. This information is used in helping determine the most appropriate placement and treatment options for these children. CRP currently maintains 826 intelligence quotient reports on 588 children currently committed to DCBS. In 2018, 271 intelligence quotient reports (on 248 children) were entered into the CRP database. Please note that some children have more than one intelligence quotient report.

CRP has designated staff who work closely with the DCBS Medical Support Team to assure that all medically complex children are identified and tracked appropriately and that level assignments for these children are as accurate as possible based on both the child's medical needs and other issues or behaviors. During the last year specifically, CRP staff worked with the DCBS Medical Support Team to improve the redetermination process for children whose medically complex status or acuity change

while in placement. In 2018, CRP tracked 326 DCBS children who were identified as medically complex at some time during the year. CRP communicates with DCBS, PCCs, and PCPs on a daily and ongoing basis regarding levels of care and other issues of concern.

Placement:
CRP's regional placement coordinators are responsible for assisting DCBS staff in locating the placements that best meet a child's needs. CRP's database identifies placement options based on the child's age, level of care, gender, intelligence quotient, and the proximity of the program to the child's home county. An effort is made to keep siblings together whenever appropriate. CRP staff was involved in 5055 placements in 2018. This is a decrease from 2017, however, the number of referrals per placement increased from 50.6 to 73.1 leading to an overall increase in the number of referrals. Placement coordinators made over 369,000 referrals in 2018.

Calendar Year	# of Referrals	# of Placements with RPC Involvement	Avg. # of Referrals per Placement
2018	369604	5055	73.1
2017	309,279	6111	50.6
2016	295,633	6800	43.5

In addition, CRP provides information to DCBS staff about placement options for referred children, so that placement decisions can also be based on the PCC's or PCP's ability to provide treatment services for the child's identified treatment needs. CRP maintains information on more than 160 PCC and PCP programs statewide (including residential treatment, foster care, and independent living programs) regarding the evidence-based practices and other services they provide to meet the treatment needs of state committed children. When placement options based on a referred child's age, level of care, etc. are identified, the regional placement coordinator shares information with the DCBS worker about the types of evidence-based practices and other services each program offers to address the treatment needs of the child being referred. CRP maintains a list of descriptions for the more than 80 evidence-based practices reported as being used at some point by the PCC and PCP programs (59 are reported as currently being used by 120 programs) and updates these as needed. These descriptions are provided to DCBS so that they can be posted on the DCBS website.

Another source of information provided to DCBS staff is the comparative report. This report is produced by CRP and updated quarterly for each PCC and PCP and includes information about admission criteria, services provided, staff qualifications, and how they compare to other similar programs in various areas including safety and permanency. In addition, the regional placement coordinators request foster home "snapshot" reports on any foster family considering placing a child and may request complete home studies on specific families from PCPs at the DCBS worker's request. The regional placement coordinators work diligently to make sure that staff in the individual DCBS regions have available the information they need to make good placement decisions and encourage DCBS staff to use the reports and information that CRP provides when making those placement decisions, especially when there are multiple placement options.

CRP statewide placement staff, in addition to the regional placement coordinators, are frequently involved in conference calls with DCBS staff and others to determine the most appropriate placements and services for children. CRP routinely convenes telephone conference calls to discuss and address difficult placements, for decision making on locating placements that best meet the needs of DCBS children, and for clinical consultation. In 2018, CRP staff were involved in approximately 760 conference

calls. This is an increase of more than 11% over 2017. For conference calls on children 16 and over, independent living coordinators may be invited to participate to ensure the region follows appropriate steps to prepare children for aging out of the system. Guardianship staff are invited to participate in conference calls on youth over the age of 18 who may be in need of these services as they get closer to aging out of the DCBS system.

Because of the number and types of children in DCBS custody who are placed in psychiatric hospitals, it is important that CRP staff maintain relationships with psychiatric hospitals and MCOs. CRP tracks children in psychiatric hospitals through a census report generated by CRP to be updated and returned to CRP by the hospitals on a weekly basis. In addition, CRP supplements the census report by obtaining information from the hospitals and MCOs on an ongoing basis to be proactive in placement efforts with the goal of beginning discharge planning at the time of admission. CRP maintains and utilizes lists for children who are difficult to place and/or are in hospitals to effectively communicate with DCBS central office staff on challenging cases and updates these lists, as needed, to meet the changing demands of managed care. These lists are also used to track children who are at risk for disruption or decertification or whose services have already been decertified by the MCO at their current placement.

As part of the placement process, CRP works closely with the MCOs. Some of the MCOs are willing to put additional services in place for children to help move them to or maintain them in less restrictive or more community-based settings, including moving children back to Kentucky from out-of-state placements. CRP also routinely interfaces with the MCOs on difficult-to-place children to discuss whether these types of additional services would be available to support a child in Kentucky before out-of-state placement is considered. CRP works with the MCO, potential placing agencies, and DCBS to determine placement options and the additional services that would be needed to support the child once placed.

CRP maintains a list of PCP medically complex foster homes (homes in which the foster parents are trained to care for children with significant medical needs) to assure appropriate referrals for medically complex children. There are currently more than 221 homes on that list. CRP monitors the DCBS PCC tracking system for medically complex foster homes. If a foster home is no longer listed as medically complex in the PCC tracking system, it is removed from the CRP list. CRP also provides a monthly report to DCBS identifying any medically complex children who are placed in non-medically complex homes. If a new foster home is added as medically complex in PCC tracking, CRP contacts the PCP and asks for a checklist to verify that the home meets the necessary regulations before adding them as a medically complex resource in the CRP database. This list of homes is available to the regional placement coordinators for use when making placement referrals on medically complex children.

Regional placement coordinators refer to transitional and independent living programs as appropriate. The CRP database provides a list of independent living programs providers by county and region. CRP's comparative report provides additional information about each resource. Currently, CRP lists 13 agencies with 37 separate programs licensed to provide independent living programs services to state committed children.

CRP staff are actively involved in transitioning children who have been placed in out-of-state treatment programs back into placement in Kentucky. CRP convenes telephone conference calls as appropriate with DCBS staff, current out-of-state treatment providers, and others as needed while the child is in the out-of-state placement, again approximately one month after the child's return, and then at ongoing regular intervals as needed to support and maintain the placement. The number of children in care had

been decreasing over time and in 2015, nine children were placed in out-of-state treatment sometime during the year and only two were in out-of-state placement at the end of the year. In subsequent years, the number of children in out-of-state placement had been gradually increasing, but in 2018, the number of children placed in an out-of-state program sometime during the year nearly doubled to 27 and 16 were in out-of-state treatment programs at the end of 2018.

Calendar Year	# Children Out of State During the Year	# of Children Out of State at End of Year
2018	27	16
2017	15	6
2016	11	4
2015	9	2
2014	19	7

CRP staff work closely with DCBS to address the needs of the developmentally and intellectually disabled populations especially as they begin to age out of the DCBS system to assure a smooth transition to the adult system. CRP has a consultant for developmental and intellectual disabilities who works with DCBS to help determine the most appropriate placements to meet the youth's needs. The consultant completed 46 written consultation reports in 2018 (up from the 39 completed in 2017). CRP staff may at times work with supports for community living programs to have them consider placing these youth under an individual placement agreement until supports for community living funding is available for the youth at 20.5 years of age. This may serve to reduce the number of transitions for the youth. From 2015 to 2017, the number of youth utilizing supports for community living services remained stable. However, in 2018, the number increased significantly to 92 DCBS youth being placed with a supports for community living provider sometime during the year and 74 DCBS youth being placed with supports for community living providers at the end of the year.

Calendar Year	# Youth in Supports for Community Living Placement During the Year	# of Youth in Supports for Community Living Placement at End of Year
2018	92	74
2017	76	45
2016	70	50
2015	69	54

DCBS currently works with two different agencies that have 5S (specialized) residential programs for high intensity children. CRP has been involved in helping determine children's appropriateness for placement in these specialized services programs and has facilitated conference calls to discuss related referrals and placements. CRP staff also review the records of these programs to determine if agreed upon services have been provided. These service reviews are provided to DCBS and to the programs. During 2018, CRP completed 172 service reviews for Maryhurst Specialized Services Program and 40 service reviews for Uspiritus Brooklawn Specialized Program. Service reviews are completed on a quarterly basis for each youth in the program. In 2018, 89 different children resided in these programs (71 in Maryhurst and 18 in Uspiritus). CRP has continued to make
revisions to the reviews and aggregate reports to address requests from the programs and DCBS, such as tracking youth who have completed high school while in the program and tracking the average number of days for youth to complete the program.

CRP communicates with DCBS and/or PCCs/PCPs on a daily and ongoing basis regarding placement referrals for children, clinical consultation, and other issues of concern.

Quality Assurance:
CRP receives quarterly or semiannual reports from the PCCs and PCPs regarding each child in their care. Through these reports, CRP is able to monitor some aspects of service provision by the PCCs and PCPs. As CRP's clinical reviewers review these reports for level assignment information, they also note any concerns about a child's safety or the services he/she may or may not be receiving. These quality improvement issues are also tracked by program. Depending on the seriousness of the concern, it may be reported in detail to DCBS or in a general (at least monthly) summary report. During 2014, CRP made this quality improvement information available to the PCCs and PCPs online through the CRP web application. With the online access, PCC and PCP staff can readily review any issues that have been noted about their programs and utilize the information for program improvement purposes. During 2016, CRP entered 2653 quality improvement issues. This was down some from the more than 3000 quality improvement issues that were entered in 2015. During 2017, CRP identified 3652 quality improvement issues and in 2018, 3913 were identified. The numbers have continued to increase over the past two years even though the PCCs and PCPs have access to the information and are encouraged to use it for their own quality improvement purposes. Some of the increase in the number of quality improvement issues identified may be due to the increase in the number of children in OOHC, which in turn impacts the number of utilization reviews completed (8287 in 2018 versus 7948 in 2017). In addition, CRP continues to monitor and adjust the system as necessary (For example, at the cabinet's request, the definition for inadequate substance use treatment was tightened in order to identify this issue more accurately). Nevertheless, the increase in quality improvement issues remains a concern.

DCBS has a tracking system for children in private foster care, residential, and independent living placements. CRP receives a weekly download from DCBS, which is integrated into the CRP system to ensure that placement information is as current and accurate as possible. In 2016, CRP reconciled 15,279 PCC tracking records with information in the CRP web application. In 2017, CRP reconciled 19,192 PCC tracking records with information in the CRP web application. In 2018, CRP reconciled 19,004 records.

CRP works closely with the PCC and PCP providers through their association, the Children's Alliance of Kentucky, to improve outcomes for children in the custody of DCBS. A joint bimonthly Quality Outcomes for Children Council meeting provides an opportunity to plan and track joint quality improvement activities.

CRP staff also work collaboratively with the PCC and PCP community to update comparative reports on a quarterly basis. This includes frequent email and telephone contact with providers around the state as part of CRP's effort to encourage accurate reporting of the data contained in these reports. Each program's comparative report provides information on program characteristics that may be used in helping determine the most appropriate placement for a child.

A trend in the last year that affects all of CRPs functions is the continued increase in the number of children in OOHC (approximately 8011 at the end of 2015, 8254 at the end of 2016, 8666 at the end of 2017 and 9747 at the end of 2018).

The data shows that the number of children in out-of-state programs had been increasing gradually over the previous two years but made a bigger increase in 2018. This may be due to an insufficient number of appropriate placement resources within the state to accommodate the increasing number of children in care. At the end of 2015, only two children were placed in out-of-state treatment programs. At the end of 2016, there were four DCBS children placed out-of-state treatment programs, at the end of 2017, there were six, and at the end of 2018, the number has grown to 16. Medicaid MCOs continue to seem reluctant when it comes to approving out-of-state placements for Kentucky children. Some have offered alternatives such as increased support in existing Kentucky programs. Alternatives have actually been implemented in only limited situations where there has been CRP involvement. Due to the significant and specific treatment needs of some Kentucky children and ongoing issues with resource availability, it is possible that more children will be placed out-of-state in the coming year. CRP provides a monthly report to DCBS central office regarding the number of children in out-of-state placement and the number being referred.

The number of level assignments and placement referrals continues to increase which is due in large part to the increasing number of Kentucky children in OOHC and limited resource availability. What may not be as clear from the data is that, as the number of referral episodes has increased, so has the amount of time and effort involved in locating appropriate placements. Many children have to be referred several times on a statewide basis before an appropriate placement can be located. Even though the number of placements the regional placement coordinators were involved in during 2017 was down slightly from 2016, the number of actual referrals (and referrals per placement) increased significantly (from an average of 43.5 referrals per placement in 2016 to an average of 50.6 in 2017). Another significant increase occurred in 2018 when the average referrals per placement jumped to 73.1. There continues to be a significant number of children who are considered “difficult to place” and it may take many rounds of referrals to find a placement. In addition, many of these difficult-to-place children remain in hospitals, even though their stays have been decertified by their MCOs, due to the time it takes and the number of referrals that must be made before a placement is found

The number of conference calls on difficult-to-place children increased by more than 11% in the last year. Even though DCBS central office has been working to involve regional leadership in problem solving before conference calls are scheduled and has been trying to streamline the processes in other ways, the large number of difficult-to-place children drives the need for the high volume of calls. Although finding placement/treatment options for difficult-to-place children is the primary focus on the majority of the calls, conference calls are also convened to address questions or to reach consensus regarding placement or treatment recommendations and to explore ways to prevent disruption and assure successful transitions.

The number of quality improvement issues identified by CRP decreased from 3000 in 2015 to 2653 in 2016, but in 2017, they increased by over 35% to 3652 and in 2018, they increased by more than 7% over the previous year for a total of 3913. Some of the increase in the number of quality improvement issues identified may be due to the increase in the number of children in OOHC, which in turn impacts the number of utilization reviews completed (8287 in 2018 versus 7948 in 2017). However, the increase in quality improvement issues remains a concern. The quality improvement information has been available to the PCCs and PCPs online through the CRP web application since 2014 and it was hoped that PCCs and PCPs would utilize the information for their own quality improvement purposes, especially those related to documentation issues. CRP will continue to work with DCBS to encourage programs to access and utilize their Quality Improvement data.

During 2018, CRP continued to expand the number and types of reports and data available online where possible. A new online referral system was developed during the year with a rollout in January of 2019. In addition, there is a plan in place to collect comparative report staff updates through the CRP web application. A continuing focus of 2019 will be to implement and improve the updated web application and to continue to expand the use of electronic communication and reporting where appropriate.

In 2018, CRP continued development of reporting dashboards with information about PCCs and PCPs such as: number of referrals received and related responses, timeliness of required reporting to CRP, information regarding quality improvement issues, etc. The prototype has been shared with DCBS and the Quality Outcomes for Children Council and has received positive reviews. CRP will continue to work on making the dashboard available to providers in the coming year through the CRP web application. CRP will continue to provide the CRP Monthly Activity Dashboard and the Provider Capacity and Occupancy Dashboard to DCBS central office on a monthly basis.

CRP will actively support Kentucky's child welfare transformation during the coming year. The transformation effort will include many components such as the Family First Prevention Services Act (FFPSA), legislative session 2018's House Bill 1 (including Performance Based Contracting and Privatization), and the move toward "decoupling" services provided by the PCCs and PCPs (currently planned for July 2020). CRP staff have been actively involved in meetings and have attended presentations regarding these efforts. CRP is working with the Cabinet on FFPSA issues including helping the Cabinet develop a protocol for the assessment required to determine whether placement in congregate care (Qualified Residential Treatment Programs) is appropriate for individual children. CRP provided data for the Performance Based Contracting portion of the House Bill Study Group and actively participated in meetings, which led to recommendations to the legislature. In 2019, CRP will maintain involvement in the study group as the issue of privatization is addressed. CRP will also work closely with DCBS on their plans for decoupling and will provide support and information/data as requested.

CRP will continue to collect and report quality improvement issues and encourage their review by the PCCs and PCPs in order to help inform areas that may become greater issues of concern when decoupling occurs.

DCBS has recently begun implementing "disruption consultations" in an effort to reduce the number of placement changes for children by trying to prevent disruptions before they occur. CRP's regional placement coordinators are involved in these efforts and will continue to support the cabinet in addressing the issue of disruption.

The number of non-level of care or non-traditional treatment programs, including several pilots, has been or is being developed across the state. CRP will continue to adapt workflows and procedures to support these efforts. CRP will continue to work with DCBS to address placement issues (e.g., number of children placed out of state and issues related to their return, addressing placement needs of difficult-to-place children, improving placement processes, etc.). In the coming year, CRP will continue to communicate with and work with DCBS to meet other needs as they arise.

H. Community Collaboration for Children, Community-Based Child Abuse Prevention, and Promoting Safe and Stable Families

The Community Collaboration for Children (CCC) is funded by Promoting Safe and Stable Families (PSSF) and the Community-Based Child Abuse Prevention (CBCAP) program. PSSF funds are used exclusively for direct services. CBCAP funds are used for direct services, the regional network, and other initiatives

such as child abuse prevention awareness (especially in April), fatherhood, and faith-based activities. Both CBCAP and PSSF funds are used to develop, operate, expand, and enhance community-based and prevention-focused programs. Two direct services are currently provided through these funding streams: In-Home Based Services (IHBS) and parent engagement meetings (PEMs). Both services are funded by a combination of CBCAP grant funds and PSSF funds.

1) IHBS are in every county across the state. This service targets low-risk families, such as families who have children with disabilities, teenage parents and parents who are young adults, parents with disabilities, young children, low incomes, and families who are struggling with other issues. IHBS are short-term, home-based services geared to develop, support, and empower the family unit. IHBS teaches parent education, child development, problem solving skills, appropriate discipline techniques, and how parents can become self-sufficient by coordinating available community resources.
2) PEMs have the same target population but are only available in Jefferson County and one rural region where there was a recent expansion. PEMs bring families, agencies, and community partners together to resolve issues that exist within the family. Facilitators ensure an objective discussion of issues and explore resources. Referrals are accepted from DCBS and from the school system. PEMs target school-aged children (ages 5-11) who are at risk of educational neglect. In 2018, 344 families received PEM services and 86% of those cases were diverted from being involved with the child welfare system.

CCC is divided into 17 service areas (comparable to the area development districts (ADD)) and the service areas cover all 120 counties. CBCAP exclusively funds the regional networks that are located in each of the CCC service areas, which cover the entire state. Each region has an established regional network whose membership requires representation from DCBS; CCC service providers; Early Childhood Councils; Family Resource and Youth Service Centers (FRYSCs); health departments, mental health service providers, and court officials; domestic violence shelter representatives; other child and family serving prevention agencies; community leaders (including those in the faith community); and local citizens including parents. A regional network is a community-based collaborative within each service area whose members meet at least five times per year. The regional network provides collaboration and support to CCC service providers. The members share regional resources, discuss child abuse prevention in local communities, discuss needs of the regions, and share data. Regional networks are a unique component of the program and fulfill the statewide network requirement of the CBCAP program instructions.

Each regional network and collaborative partners bring data and issues to the network. Networks work to set priorities and allocate funding available based upon those priorities. Increased awareness of child abuse and neglect issues is always a primary focus, especially during the month of April, which is Child Abuse Awareness Month. Activities and information are targeted to issues identified within the community. Providers of in-home services participate in a continuous quality review process to assist with improving services to families involved with CCC.

In 2018, IHBS served 580 families with 1,767 children. Staff now remain in the home for longer periods of time, which leads to fewer families served. Trainings to provide IHBS and parenting education classes are provided by the DCBS Training Branch and have been developed to reflect all DCBS requirements, as well as promote strengths-based principles for family engagement. CCC vendors participate in quarterly statewide meetings and regional coordinator and supervisor orientations. CCC currently employs two

parent leaders. Parent leaders work with parents to build leadership skills and to increase parent participation in the regional networks on a regional and statewide level.

CCC's work on the Child and Family Services Plan is an ongoing task with direct services and federal mandates such as fatherhood initiatives, faith-based initiatives, and collaboration with various suggested agencies such as early childhood service providers. CCC IHBS staff continue to provide Ages and Stages Questionnaire: 3, and Ages and Stages Questionnaire: Social and Emotional screening to all children under the age of 5 ½ years. Utilizing these tools helps to identify children in need of services for further prognoses. Increased use of data to identify needs or gaps in service has been encouraged to assist the regional networks with planning. CCC was integrated into sophisticated data collection systems during CY 2010 in order to build capacity for enhanced data analysis and reporting. Access to better data collection and analysis has contributed to progressive improvements in service planning, delivery, and outcomes.

IHBS and PEMs are coordinated separately from the regional networks. However, reporting on the status of services, client needs, trends, and counties served occurs at regional network meetings. Regional networks use available funds to further meet the needs of clients in the region by providing opportunities such as local mini-grants to supplement parenting education, access to training and other resources, as well as local community initiatives targeting prevention of child abuse and neglect.

IHBS continue to be the most effective and in-demand service for prevention of child abuse and neglect. Regional network collaborations continue to be critical, as funding becomes increasingly tight and creative solutions, as well as decreasing duplication of services, are needed.

Data reflects a decrease in the number of overall families served and an increase in children receiving services. Multiple families residing in the same home as well as the increase in family size appear to be contributing factors. Family issues are more complex and require increased services. There continues to be an increase in relatives/grandparents caring for grandchildren/relative children as parents are increasingly involved in substance abuse or with mental health issues. Possible contributing factors include but are not limited to economic issues/availability of employment and resources, continued increases in costs for food, shelter, utilities, and basic living expenses, and transportation issues. Substance abuse and mental health issues continue to remain contributing factors in many of the families receiving CCC services. The expectation is that positive outcomes for families will be reflected in North Carolina Family Assessment Scales (NCFAS)-G scores and overall family functioning.

The CCC program will continue to focus on IHBS across the state. Flat funding prevents expansion and decreases the ability to retain employees due to a lack of salary increases over several years. Based upon the positive outcomes of PEMs, an expansion will occur in another rural community. PEMs have deferred families from becoming involved with the child welfare system. The only current barrier the program is facing is lack of funding.

I. Community Services Block Grant

The mission of the Community Services Block Grant (CSBG) is to reduce and eliminate poverty by providing opportunities for education, technical training, and employment that will improve living standards among those with low income and provide the client with dignity and self-respect. The efforts are for promoting self-sufficiency for the clients CSBG serves and to reduce the burden of dependency. The CSBG program is federally funded through the United States Department of Health and Human

Services (HHS), Administration for Children and Families, Office of Community Services, and Division of State Assistance.

CSBG services are available statewide in all 120 counties. The services are made available through all 23 Community Action Agencies (CAAs) within the state for clients that meet eligibility requirements based on 125% or below the federal poverty level. CSBG funds are allocated through CHFS. CHFS is responsible for administration, oversight, and allocation of the CSBG funds to the eligible entities within Kentucky.

The CAAs and CHFS' DCBS service regions shall work in partnership to provide services, which complement the common mission and outcomes, to prevent child maltreatment, to promote quality foster care and adoption services, and to assist vulnerable adults or low-income families. Both parties shall have a joint referral mechanism to identify and address the vital service needs of the CAAs geographic area and prevent the duplication of services.

Each CAA has a tripartite board that fully participates in the development, planning, implementation, and evaluation of the program serving that geographical area. The tripartite board must be composed of one-third democratically elected representatives of low-income individuals or families who reside in neighborhoods being served; one-third elected officials holding office at the time of their selection, or their representatives; and one-third of the board must be chosen from "business, industry, labor, religious, law enforcement, education, or other groups and interests in the community served." The tripartite board must operate in accordance with KRS 273.437 and KRS 273.439 (2). Governing boards and community action boards adopt written bylaws that include: the purpose of the CAA; duties and responsibilities of the board; number of members on the board; qualifications for board membership; types of membership; the method of selecting a member; terms of a member; offices and duties; method of selecting a chairperson; a standing committee, if applicable; provision for approval of programs and budgets; the frequency of board meetings and attendance requirements; and provision of official record of meetings and action taken. The board meeting minutes are provided to CHFS, per the master agreement between the agencies. After approval by the board and signature of a board's designed official, the minutes are sent to a policy analyst at DCBS, each board member, and the executive director.

Pursuant to KRS 273.441 (1) (e), each CAA collaborates and encourages business, labor, and other private groups and organizations to work together to encourage support of community action programs in order to provide additional private resources and capabilities.

Community Action for Kentucky provides technical assistance and training to the CAAs, a contract agent on behalf of CHFS. Additionally, CHFS offers technical assistance as needed and annual training to the CAAs to aid them in the preparation of their CSBG annual plan and budget proposals. Community Action for Kentucky has provided training to the CAAs on case planning for CSBG services.

The CAAs submit an annual plan and budget proposal to CHFS. Each plan outlines CAAs' efforts to appropriate funds, efforts, and services to low-income families in their communities. The plan requires a needs assessment process so the agencies can determine how to prioritize the domains outlined by module 2 of the annual report. The plan and budget proposal also sets forth a budget in accordance with 42 U.S. C. 9907. The funds are distributed to the CAAs by CHFS in accordance with 922 KAR 6:045.

Each CAA is required by 42 U.S.C. 9917 to implement Results Oriented Management and Accountability (ROMA). Results-management reporting impacts the way agencies document the results of their efforts. This tool is used in planning, organizing, directing, and self-evaluation. ROMA focuses on three broad areas: family, agency, and community.

OCS has enhanced the CSBG network's performance and outcomes measurement system for local eligible entities identified in the CSBG Act as ROMA Next Generation (ROMA NG). This will improve the tracking and accountability measures reported by the CAAs and CHFS.

New goals have been implemented for ROMA NG, based on the theory of change. The following are the new community action goals:

1) Individuals and families with low income are stable and achieve economic security;
2) Communities where people with low incomes live are healthy and offer economic opportunity;
3) People with low incomes are engaged and active in building opportunities in communities.

CAAs collect data utilizing the CSBG expenditures domains and the National Performance Indicators (NPIs) which are part of the annual report, module 2 through module 4. CSBG funding during the reporting period should be identified in the domain that best reflects the services delivered and strategies implemented. The CSBG expenditures domains listed in module 2, section A are as follows: employment, education and cognitive development, income infrastructure and asset building, housing, health/social behavioral development (including nutrition), civic engagement and community involvement, services supporting multiple domains, linkages, and agency capacity building. The CAAs submit the ROMA NPI reports to Community Action for Kentucky on a quarterly basis. Community Action for Kentucky submits the cumulative reports to the state at the end of the state fiscal year.

In order to meet the requirement of Performance Measurement under Section 678E(a)(1)(A) of the CSBG Act, CHFS submits Modules I-IV of the CSBG Annual report through the Online Data Collection operated by the Administration for Children and Families in pursuant of CSBG information memorandum 152. The CSBG Annual Report replaces the CSBG IS Survey. The four modules include (1) State Administration, (2) Agency Expenditures, Capacity, and Resources, (3) Community Level, and (4) Individual and Family Level. The modules "outline accountability and reporting requirements, including the establishment of a performance measurement system through which States and eligible entities measure their performance in achieving the goals of their community action plans" (information memorandum 152). Module I is completed by the cabinet and Modules II-IV will be completed by CAK. The modules will be reviewed and then submitted by the cabinet. The complete Annual Report will be submitted to the federal government by April 30, 2019.

DCBS completes biannual block grant status reports on CSBG for the state legislature in January and July. The status report reflects activities completed in the past six months such as expenditures, objectives, achievements, authorized changes, and evaluation of results. CHFS performs monitoring of the CAAs to determine the agencies' compliance with applicable federal and state regulations and statutes, programmatic and financial requirements, and the agencies' adherence to the CSBG plan and budget proposal. The Division for Administrative and Financial Management (DAFM) performs monitoring for the CAAs' activities at the DCBS level. Monitoring is conducted on the calendar year. Each agency will be monitored at least once every three years. Depending on the findings of the monitoring, the CAAs may be required to submit a plan of corrective action. The CAAs are also subject to audit requirements

per 2 CFR Part 200, Subpart F. CHFS, in cooperation with CAK, also monitors each of the 23 CAAs annually for the CSBG Organizational Standards in accordance with information memorandum 138.

J. Court-Appointed Special Advocates

Kentucky Court-Appointed Special Advocate (CASA) Network, Inc. (KCN) is the state association for CASA programs. CASAs are trained volunteers, supervised by CASA programs, who are appointed by a judge to represent the best interests of dependent, abused, and neglected children in court. KCN assists in the development of new local CASA programs, monitors practices and policies of local CASA programs, and provides technical assistance to local CASA programs. KCN collects data from local CASA programs pertaining to the numbers of volunteers trained and children served. While the KCN does not administer CASA programs, for the period October 1, 2017-September 30, 2018, KCN collaborated with a new local program to provide direct services in its counties. Funding sources include Kentucky Justice and Public Safety Cabinet State CASA Grant, VOCA Grant, National CASA Association Grant, James Graham Brown Foundation Grant, membership dues, fundraising events, and donations.

KCN is a statewide association. In 2018, there were 56 counties served by 22 local CASA programs. KCN works with local family courts (or district court if there is no family court) to establish local CASA programs in unserved areas.

KCN collaborates with local CASA programs across the state. Two members represent local CASA programs on the board of the KCN. KCN staff regularly communicates with local CASA programs through newsletters, conference calls, and email. KCN problem solves with local CASA programs about matters affecting programs individually and as a group. KCN and local CASA programs have collaborated on grant requests. KCN provides joint training opportunities for local CASA programs and in 2018 organized a statewide CASA conference.

KCN collaborates with various other local and statewide organizations, including, but not limited to: Kentucky DCBS, Kentucky Administrative Office of the Courts, Kentucky Youth Advocates, and local family courts. KCN staff serve on advisory committees for the Kentucky Victims Assistance Academy (coordinated by the Kentucky Justice and Public Safety Cabinet) and Prevent Child Abuse Kentucky Conference Advisory Council. KCN also serves on the Child Fatality Review Panel and CJA task force. KCN works collaboratively with the state association for CACs and other service providers during conference calls, meetings, trainings, and through information and data sharing.

Statewide, CASA programs experienced growth in volunteer advocates from 980 in 2017 to 1112 in 2018. Advocates served 3514 dependent, abused, and neglected children during 2018 and 430 new volunteer advocates were trained.

Local CASA Programs	2015	2016	2017	2018
Children Served	2,895	2,831	>3,000	3,514
New Volunteers Trained	241	285	389	430
Total Active Volunteers	808	831	980	1,112

In 2018, one local CASA program received full membership with the National CASA Association and two new programs obtained provisional membership with the National CASA Association. Two established programs expanded into neighboring counties.

In 2018, KCN provided and facilitated 12 training opportunities for local CASA program staff and board members and hosted the largest state conference (for volunteers, staff, and board members) to date with 300 attendees.

KCN concluded its 2016-2018 Quality Assurance Review for the twenty established CASA programs.

For fiscal year 2019, KCN was made the administrator of the State CASA grant funds available through the Justice and Public Safety Cabinet. This increased administrative function required KCN to adopt new policies and practices and is requiring the KCN to re-organize operations.

KCN's 2018-2021 Growth Plan includes increasing the CASA program footprint into 24 new counties by the end of 2021 and adding three new multi-county programs. Barriers to increasing the CASA footprint is the number of counties in Kentucky, which can make sharing resources more complicated, and maintaining local organizers' full engagement through the process of establishing a CASA program. Another goal is to increase the number of total active volunteers to 1,400 by the end of 2021 so that CASA advocacy services are provided to more children. Barriers to achieving the increased volunteers is improving volunteer retention and raising awareness of CASA to attract new volunteers.

K. Diversion/Intensive In-Home Services Program

The Diversion program services are provided to TANF-eligible families with children ages 5 through 17 who are at risk of removal from their biological families, relatives, or finalized adoptive families. Services are also provided to those children who are in OOHC and have a plan to be returned to their families. The primary goals of the Diversion program are to 1) safely divert from OOHC children committed to DCBS or who are at risk of commitment and placement in OOHC, and 2) return children who have recently been placed in OOHC but who, with in-home services, could be returned safely to their home. The program provides a timely (within 10 days of referral) initial clinical assessment by a staff person with at least a master's degree in social work. The provider develops and implements an intervention plan that addresses the identified needs of the family. The family plan focuses on short-term needs and long-term sustainability of child safety.

An array of services is provided based on a comprehensive family assessment. The services must be family-focused and designed to keep children in the home without facing additional abuse or neglect. The target population is children and youth who are 5-17 years of age who can be safely maintained in or returned to their home with services. These services primarily include preservation and reunification services, clinical assessments, therapeutic child support services, parent development program, and crisis intervention services. The provider works around the family's schedule and the diversion specialist is available to the family 24 hours a day, seven days a week.

A family service plan is developed within the first 30 days of entering the program. Program staff network and collaborate with community supports and resources such as community mental health centers (CMHCs), schools, faith-based services, housing, transportation, and medical services that can be utilized for sustained self-sufficiency. A wrap-around service delivery approach, including intervention and treatment plans, is then implemented. The family intervention lasts 3-4 months, depending on the needs and progress of the family. Follow-ups are completed at 3 months, 6 months, and 1 year after the family intervention to assess the success of the intervention.

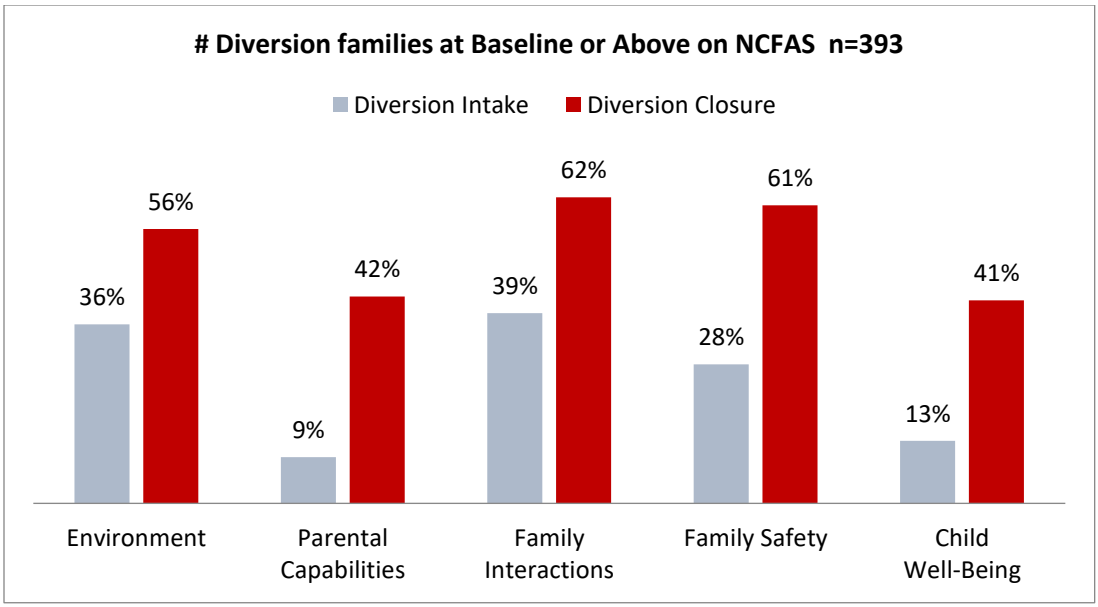
In calendar year 2018, 750 families with 1285 children were referred to the Diversion Program and 608 families with 1103 children were accepted into the program (data retrieved 03/19/2019).

Five hundred and five of 608 families accepted into the Diversion program were considered to have successfully completed the service. In addition, 1065 of 1103 target children successfully completed the program indicating a 97% success rate. A percentage rate of 75% or more children remaining home safely at closure is an outcome measure that indicates that the services were successful.

Diversion Program Outcomes, Calendar Year 2018					
	Families Accepted	**Families Closed Complete**	**# of Target children at risk**	**# of children remained/ reunified home at closure**	**% of children completing services**
Diversion	511	433	975	947	97%
Diversion Reunification	97	72	128	118	92%
Totals	608	505	1103	1065	97%

Follow-up Activity Completed During Calendar Year 2018		
3 Month Follow Ups	**Diversion and Reunification**	
	Total # of Target Children with Follow Up	851
	Total # of Target Children in Home at Follow Up	810
	Percentage of Target Children in Home	95%
6 Month Follow Ups		
	Total # of Target Children with Follow Up	847
	Total # of Target Children in Home at Follow Up	751
	Percentage of Target Children in Home	89%
12 Month Follow Ups		
	Total # of Target Children with Follow Up	710
	Total # of Target Children in Home at Follow Up	593
	Percentage of Target Children in Home	84%

Families are assessed at intake and closure for family functioning using the NCFAS. The scores on environment, parental capabilities, family interaction, family safety, and child well-being range from -3 (serious problems) to 0 (adequate) to 2 (clear strength). To simplify the reporting of NCFAS scores at intake and closure, scores are dichotomized into adequate or better (a score of 0 to 2) or not (a score of -3 to -1). The percent of families completing Diversion preservation services (represented by “n”) in 2017 who scored adequate or better on each domain at intake and closure are presented below.



At intake, families scored the lowest on Parental Capabilities and Child Well-Being. These are also the two areas where the biggest gains were made at closure. It is important to note that an increase in scores in Parental Capabilities (33%) normally correlates to an improvement in scores in Family Safety (33%) and Child Well-Being (28%).

The Diversion contracts were renewed in calendar year 2018 for another biennium beginning fiscal year 2019 and ending in fiscal year 2020. As a result, service providers were able to continue accepting referrals and providing services with no disruption through the end of the year.

Economic conditions and budget constraints could affect service delivery in the future. The cabinet is committed to efforts to keeping children in their homes safely and ensuring that children in out-of-home placements can return and be maintained in their home safely.

L. Early Childhood Mental Health Initiative

The Early Childhood Mental Health (ECMH) Program promotes the social and emotional growth of Kentucky's children ages 0 to 5 by emphasizing the importance of nurturing relationships in multiple settings. There are 16 ECMH specialists across the state located at the regional CMHCs. These specialists provide consultation to early care and education settings, direct interventions to children and families identified as having social-emotional concerns, and training for early childhood professionals on social-emotional wellness and dealing with challenging behaviors. Additionally, ECMH specialists serve as a resource for their own CMHC. A key goal of this program is to build capacity of mental health clinicians to work with the population of children who are ages 0 to 5.

This program is operational statewide and initial funding is through state dollars, specifically Phase I Master Tobacco Settlement dollars. Services provided to children and families through the MCHCs are billed to Medicaid and private insurance. Program-funded opportunities for professional development are presented statewide on ECMH topics to the ECMH specialists. These trainings are at no cost and clinicians receive continuing education units that can apply to licensure requirements.

Building the capacity of early care and education professionals supports the program goal to decrease the number of children expelled from early care and education settings. The ECMH specialists provide free trainings and consultations to early care and education programs. The goal is to build capacity of early care and education professionals in addressing social-emotional issues of young children, eventually decreasing the number of expulsions and referrals to the ECMH specialists.

Many ECMH specialists are members of Community Early Childhood Councils (CECC), and some hold office within their perspective councils. The primary goal of all CECCs is to build innovative, collaborative partnerships that promote school readiness for children and families by bringing local partners together, identifying local needs, and developing strategies to address those needs. As members of CECC, the ECMH specialists assist with a variety of efforts including training community and family partners, completing needs assessment, grant writing, and resource sharing. ECMH specialists also participate in other community groups on a regular basis such as regional interagency councils and district early intervention committees.

In addition to direct services provided to young children and their families, ECMH specialists conducted 2371 consultations with early childhood professionals in 2018. ECMH specialists provided 39 trainings to a variety of early care and education personnel and other stakeholders. Finally, they participated in 601 early childhood meetings including CECCs, district early intervention committees, CCC Regional Networks, and Family Resource Youth Service Centers.

M. Family Alternative Diversion

Family Alternative Diversion (FAD) provides temporary assistance to stabilize families and maintain self-sufficiency as an alternative to applying for ongoing cash assistance. FAD is available to Kentucky Transitional Assistance Program (K-TAP) eligible families not currently receiving cash payments who are at or below the gross income limit for K-TAP for the appropriate family size. FAD is administered statewide and is funded by title IV-A. Families eligible for FAD may receive up to $1,300 to pay for verified short-term needs. The types of benefits provided include assistance with transportation, childcare, shelter, utility costs, or employment-related expenses. FAD has a 3-month eligibility period and is not considered cash assistance. Therefore, FAD does not count towards the 60-month lifetime receipt limit of cash assistance. FAD may not be received more than once in a 24-month period and is limited to twice in a lifetime. Receipt of FAD payment excludes the benefit recipient from receiving ongoing K-TAP benefits for 12 months, unless non-receipt would result in abuse or neglect of a child or the parent's inability to provide adequate support due to the loss of employment through no fault of the parent. In addition to being determined eligible for FAD, additional services or referrals that may also be offered include Supplemental Nutrition Assistance Program, Medicaid, child care assistance, child support, and employment services.

Individuals do not apply for FAD, but are screened for FAD eligibility when applying for K-TAP by local staff. If it is determined a family could benefit from FAD, the family is given the opportunity to choose to receive either FAD or ongoing cash assistance. To receive FAD payments, all short-term needs must be verified. Once expenses are verified, payments may be issued to either a vendor or vendor and applicant. During calendar year 2018, an average of 17 families per month received a FAD payment. The average payment per family per month was $751.99. No policy or procedural changes have been made to the FAD program during calendar year 2018. CHFS does not currently have plans to revise the program.

N. Family Preservation Program

The Family Preservation Program (FPP) describes an intensive, in-home crisis intervention resource using approved intensive family centered evidence-based practice models. The primary goal of the services is to support the cabinet's efforts to ensure safety, permanency, and well-being of children by preventing unnecessary placement of children in OOHC, facilitate the safe and timely return home for a child or youth in placement, as well as enhance protective and parental capacities of caregivers.

The Family Preservation service array includes IFPS for families with children at imminent and immediate risk of out-of-home placement; FRS to help children in OOHC return to their families; and FACTS for families with children at risk of out-of-home placement or returning from OOHC. DCBS social services workers refer eligible families and referrals are screened and approved by a designated DCBS regional staff person. Families served are evaluated using the NCFAS and other clinical assessments to provide a comprehensive assessment of family functioning and determine service needs. The lower scores on the NCFAS form the basis for goal development using evidence-based intervention strategies and curricula that promote cognitive behavioral changes.

FPP services are provided statewide in all 120 Kentucky counties through contracts with non-profit agencies. Regional management teams are comprised of DCBS staff, including the person responsible for screening all family preservation and reunification referrals; the SRA or designee; the FPP supervisor; and the agency designee. This team determines any specialized FPP services and provides ongoing oversight of the services. FPP specialists and supervisors may participate in school-based meetings, coordinate mental health services, and locate both hard and soft resources such as housing, counseling, and parenting classes. FPP also networks with community partners including representatives from domestic violence shelters, family team meetings, drug task forces, IMPACT, mental health services, CACs, health departments, housing programs, and faith-based services.

FPP services provide a wide variety of family-centered and strength-based services for children and families that include a comprehensive family assessment and use of evidence-based cognitive and behavioral change strategies, crisis intervention, parent education programs, family and youth support services. Additionally, FPP specialists are available to families 24 hours a day, seven days a week.

Family Preservation and Reunification Services Continuum		
Family Preservation and Reunification Services	**Duration and Service Intensity**	**Outcomes: Calendar Year 2018 Data**
IFPS - Intensive Family Preservation Services **Referral Criteria:** Imminent risk of removal of child from home	**Duration:** Average 4-6 weeks **Service Intensity:** Intensive in-home services provided for 6-10 direct hours per week **Caseload:** 2-4 families at a time **Age limit:** 0-17 years old	934 of 990 families completed services 2,093 of 2,152 children remained safely in the home (97%)

FRS - Family Reunification Services **Referral Criteria:** Plan to return child home from OOHC	**Duration:** Average 3-6 months (extensions are based on need and progress made) **Service Intensity:** Average minimum 3-8 direct hours per week **Caseload:** Not to exceed 6 cases at a time **Age limit:** 0-17 years old	229 of 269 families completed services 433 of 452 children remained safely in the home (96%)
FACTS - Families and Children Together Safely (preservation/ reunification) **Referral Criteria:** Child at risk of removal from home or child in OOHC with a plan to be reunified with family	**Duration**: Average 3-6 months (extensions are based on need and progress made) **Service Intensity:** Average minimum 3-8 direct hours per week. Intensity is determined based on needs of family. **Caseload:** Not to exceed 6 cases at a time **Age limit:** 0-17 years old	**FACTS Preservation** 627 of 659 families completed services 1,295 of 1,336 children at risk remained safely in the home (97%) **FACTS Reunification** 160 of 173 families completed services 297 of 312 children at risk remained safely in the home (95%)
Funding State general funds and TANF MOE funds: Intensive Family Preservation Services (IFPS) Title IV-B Subpart 2, PSSF, and TANF MOE funds: Time-Limited Family Reunification Services (FRS) Title IV-B Subpart 2 and TANF MOE funds: Families and Children Together Safely (FACTS)		

From January 1, 2018 through December 31, 2018, there were 2,091 families with 4,252 children at risk of OOHC placement or reunifying from foster care participating in one of the FPP services (data retrieved March 19, 2019). Four thousand, one hundred eighteen of those children were reunified with their families or remained home safely at closure indicating a 97% success rate.

The following data shows the number of families and children served by service and the primary indicators of program goals to maintain children safely at home with the family and maintain permanency and stability in their living situations. A percentage rate of 75% or more of children remaining in the home indicates that the services were successful.

IFPS:

- 990 families accepted
- 934 families completing services
- 2,152 children at imminent risk of placement
- 2,093 of 2152 children remained safely in the home (97%)

FRS:

- 269 families accepted
- 229 families completing services
- 452 children to be reunified

- 433 of 452 children safely returned to home (96%)

FACTS Preservation
- 659 families accepted
- 627 families completing services
- 1,336 children at risk
- 1,295 of 1336 children at risk remained safely in the home (97%)

FACTS Reunification
- 173 families accepted
- 160 families completing services
- 312 children at risk
- 297 of 312 children at risk remained safely in the home (95%)

Projected numbers of families and children based on previous year's numbers for calendar year 2019 are as follows:

IFPS:
- 1,009 families accepted
- 912 families completing services
- 2,042 children at risk of placement
- 1,952 (96%) children to remain safely in the home

FRS:
- 193 families accepted
- 172 families completing services
- 326 children at risk of placement
- 313 (96%) children to remain safely in the home

FACTS Preservation
- 596 families accepted
- 519 families completing services
- 1,037 children at risk of placement
- 1,020 (98%) children to remain safely in the home

FACTS Reunification
- 149 families accepted
- 135 families completing services
- 259 children at risk of placement
- 250 (97%) children to remain safely in the home

Families and children who have completed FPP services are also followed at 3, 6, and 12 months to determine if the child who was at risk of removal (or was reunified) remains in the home. The 6-month follow up contact is a face-to-face visit with the family and child if possible and includes a review with the family of the maintenance of safety and family functioning goals.

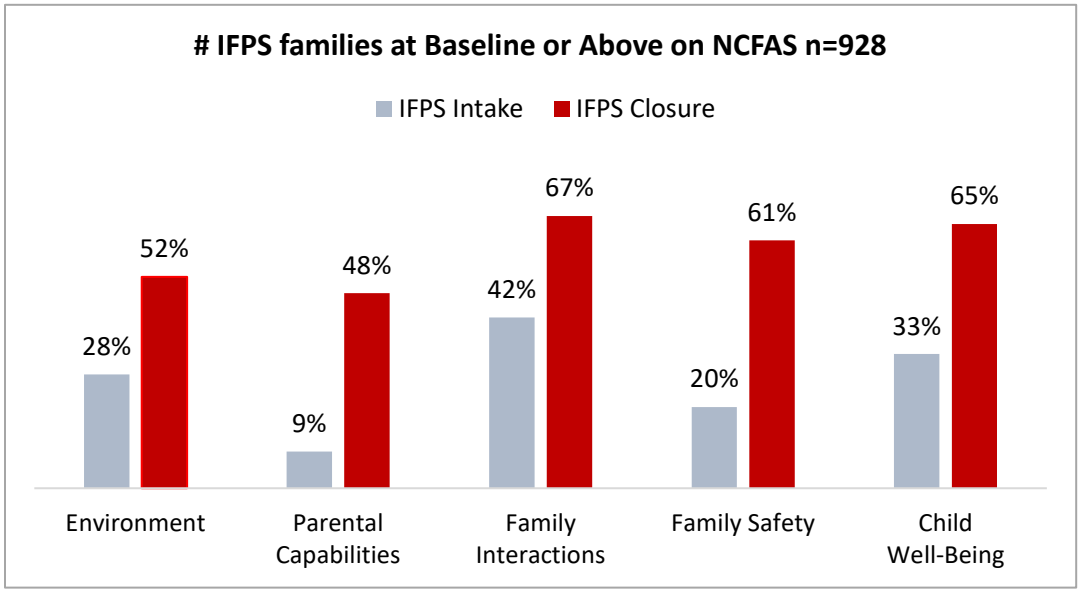
Follow-Up Activity Completed From January 1, 2017-December 31, 2017					
6-Month Follow-Up	**IFPS**	**FRS**	**FACTS-P**	**FACTS-R**	**All FPP**
# Children at Risk with Follow Up	2064	322	1097	290	3773
# Children at Risk in Home at Follow-Up	1923	279	1008	267	3477
Percent of Children at Risk in Home at Follow-Up	93%	87	92%	92%	92%

12-Month Follow-Up	**IFPS**	**FRS**	**FACTS-P**	**FACTS-R**	**All FPP**
# Children at Risk with Follow-Up	1922	295	1018	259	3494
# Children at Risk in Home at Follow-Up	1626	233	891	234	2984
Percent of Children at Risk in Home at Follow-Up	85%	79%	88%	90%	85%

Families served are evaluated at intake, closure, and at interim for services extending beyond 45 days using the NCFAS and other clinical assessments. This provides a comprehensive assessment of family functioning and determines service needs. The NCFAS comprises five domains for preservation and seven domains for reunification, which are measured on a 6-point rating scale. Rating scores and change scores measure the family's capacity to provide for the child's needs and the lower scores form the basis for goal development. Improved closing scores can indicate increased parenting capacity in areas such as supervision, discipline of children and improved family communication and problem solving.

In the chart below, outcomes for families completing IFPS (represented by "n") during 2018 are evaluated by showing the overall change in the percent of families who scored at or above baseline in each of the five categories at Intake and Closure.

NCFAS Scores at Intake and Closure: Calendar Year 2018



The chart above shows significant improvement that families made in the domains of Parental Capacity, Family Interactions, and Family Safety at the completion of IFPS services. Parental Capabilities domain is one of three domains, namely: Parental Capabilities, Family Safety, and Child Well-Being, where families referred to the Family Preservation Program usually experience low scores ranging from moderate to serious problem. Comparison of the intake and closure scores reveal that greater gains were made in Parental Capabilities (39% increase), Family Safety (41% increase) and in Child Well-Being (32% increase). An increase in scores in parental capabilities normally correlates to an improvement in scores in family safety and child wellbeing. This shift in NCFAS scores indicates that incremental and impactful improvements can be measured during the IFPS intervention.

Future direction of the program includes the following:

- All FPP in-home specialists and agencies will be trained in Trauma-Informed Care service delivery
- For state fiscal years 2018-2019, the cabinet continues to assess the statewide implementation of pre-approved intensive evidence-based practice models for In-Home Services provision.
- Since the implementation of varied evidence-based practice family-centered models, we have seen an increase in the number of families completing services and the number of children remaining home safely. This correlates to an average 37% increase in the NCFAS scores reported for the Parental Capacity, Family Safety, and Child Well-Being domains.
- The following evidence-based practices were approved for use in in-home services delivery statewide: Homebuilders Model, Solution-Based Casework, Seven Principles, Wraparound Model Active Parenting: Families in Action, and a promising evidence-based practice model called Trauma Systems Therapy Model. Complementary evidence-based therapies and intervention strategies in use include but are not limited to: Cognitive Behavioral Therapy (CBT), Trauma-Focused CBT (TF-CBT), Rational Emotive Behavioral Therapy (REBT), Motivational Interviewing (MI), Nurturing Parent, and 123 Magic.
- All FPP programs currently report their data online using the In-Home Services (IHS) Activities Data Collection tracking system. The data collected informs evaluative efforts.

- Interim checks matching data from the monthly reports submitted online are helping providers and central office improve both data entry and the quality of the reports that can be run. This has greatly improved the consistency of data reported statewide.
- The data collected is used to closely monitor service provision and to evaluate overall program improvement and quality assurance.

There are no new policies or administrative regulations affecting service provision at this time. There were no consultative efforts or technical assistance provided by the National Resource Center.

O. Family Resource and Youth Service Centers

The Family Resource and Youth Services Centers (FRYSCs) initiative was established by an act of the Kentucky General Assembly in 1990. The authorizing legislation indicates that the purpose of the local FRYSCs is to "enhance students' abilities to succeed in school." The legislation further clarifies the role of FRYSCs as focusing upon the non-academic barriers to education. The FRYSCs accomplish their mission through a comprehensive assessment of need of students, families, school personnel, and community partners. Their primary role is to serve as brokers of existing services as needs may indicate. They also are to work to identify gaps in and barriers to services as they assist students and their families. FRYSCs collect local data in the KDE's "Infinite Campus" system. Services are funded through state general fund dollars as part of the state's KDE budget. The Division of FRYSCs in CHFS provides state-level support and administrative coordination. The division of FRYSC (the state office) developed the following mission statement that encompasses the work of the initiative:

- Early learning and successful transition into school;
- Academic achievement and wellbeing while in school; and
- Graduation and transition into adult life.

At the state level, the Division of FRYSCs additionally conducts a minimum of three regional information-sharing meetings with local staff annually. Local FRYSC programs are located in 1180 of Kentucky's nearly 1250 public schools. There is at least one program in all 120 of Kentucky's counties. This initiative is a part of educational reform legislation that calls for centers to be established in or near schools where 20% or more of the school's enrollment qualifies for free school meals. In the 2000 session of the General Assembly this criterion was altered to 20% of a local school's enrollment qualified for free or reduced priced school meals. Local FRYSCs have consistently worked to either connect with or initiate local collaborative partnerships to identify current resources and expand existing networks. FRYSCs staff attend local inter-agency councils and vision groups as well as other collaborative meetings. They are also statutorily required to be a part of local early childhood councils. The local FRYSCs are also involved in numerous community groups that focus of specific issues such as substance abuse, mental health counseling, physical health issues, and numerous others. Each local FRYSC is required to have an advisory council that involves community partners, parents, and school staff. Some communities have Kentucky Integrated Delivery System meetings, which serve as a collaborative effort to case conference regarding specific needs. Many local FRYSCs are involved in writing grants to fund initiatives through their local centers.

Family Resource Centers serve children under school age and in elementary school and coordinate:

- Preschool child care
- After-school child day care
- Families in training
- Family literacy services
- Health services and referrals

Youth Services Centers serve students in middle and high school and coordinate:

- Referrals to health and social services
- Career exploration and development
- Summer and part-time job development (high school only)
- Substance abuse education and counseling
- Family crisis and mental health counseling

P. Family Violence Prevention Funds

The Family Violence Prevention and Services Grant is administered for Kentucky by CHFS, which contracts with KCADV for implementation. KCADV subcontracts with 15 domestic violence programs in the 15 area development districts across the state for direct service implementation regionally. The domestic violence programs provide shelter and related services to victims of domestic violence and their dependent children and are geographically distributed to be approximately 60 miles from any state resident. The mission of KCADV is to end intimate partner violence, promote healthy relationships, and engage communities through social change, economic empowerment, educational opportunities, and other prevention strategies. Funding for KCADV comes from the Family Violence Prevention and Services Grant, Kentucky general funds, TANF funds, Kentucky Trust and Agency, and the Social Services Block Grant (SSBG).

KCADV operates an annual training institute, which provides educational sessions for groups such as attorneys, nurses, social workers, teachers, and translators. KCADV works closely with judges and frequently participates in law enforcement trainings. Local shelter programs associated with KCADV work with child protective services across the state to reunify children and parents. All local programs are involved with local coordinating councils, which brings together child protective services and other community agencies. This effort streamlines services to resolve problems in assisting victims of domestic violence and helps to prevent future instances of violence. All programs operating under KCADV provide court advocacy to victims of domestic violence and work closely with law enforcement agencies. Services offered use a trauma-informed approach and include but are not limited to crisis lines, emergency shelter, intervention, advocacy, counseling, case management, children's services, community education, technical assistance, product development, systems advocacy, and training.

2018 Programing Additions and Highlights

- Limited therapy for children ages 8-18
- Structured summer program with activities for moms and children
- Structured age appropriate groups for residential and non-residential children, including outreach
- Domestic violence victims group for teens ages 16-19
- Transportation to services is problematic in many of our regions. Several shelters requested grant funds to obtain vehicles to address the transportation need highlighted by many survivors
- Several shelters have opened up a walk-in clinic in highly populated urban areas that are accessible by public transportation.
- Housing is a top priority and KCADV administers three current HUD grants that provide rental assistance to survivors. Two grants totaling close to $900,000 in housing funds were awarded to KCADV and BRASS in 2018 will go into effect in late 2019.
- The Green Dot Primary Prevention Program for teens lowered rates of interpersonal violence by building awareness within the community resources that could help elevate the impact of interpersonal violence on victims and their children.

- Themes for the summer activities centered on literature, related music, movies, and creative activities.
- A separate area for teens to have a space of their own that includes computers, games, comfortable seating, books, headphones, music, etc. This room has been helpful in allowing teens to relax, process their feelings, and given them a sense of belonging.
- GreenHouse 17, located in Lexington, KY, is operating a farm to create an agriculture-based healing environment to meet the needs of victims as they strive to rebuild their lives as survivors. The vision for the farm is to become an economically self-sustaining program that provides a reliable source of revenue for the agency. The farm program applies a trauma-informed care model based in the therapeutic benefits of nature-based activity. This program has received several national and statewide awards. GreenHouse 17 provides health and beauty products as well as a flower community supported agriculture program.
- Local shelter programs continue to recruit, hire, and maintain bilingual professionals on their staff in an effort to ensure the ability to access in person and/or by phone interpreters for those clients with limited English proficiency. All shelters give clients with limited English proficiency "I Speak" cards to keep with them. These cards explain the requirement of organizations that receive federal funds to provide interpreters to ensure access of services they are funded to provide. The cards also give information regarding the right to an interpreter free of charge and information regarding how agencies and businesses should respond to people who are Limited English Proficient.
- 100% of KCADV member programs have language access policies in place. Language access policies include provisions for accessing certified American Sign Language interpreters 24 hours a day, 365 days per year.
- The Women's Crisis Center in northern Kentucky continues an agreement with St. Elizabeth Healthcare. This provides crisis intervention and safety planning in their five emergency departments located across the northern Kentucky area. Staff and specially trained volunteers respond 24 hours a day, 365 days a year to victims of intimate partner violence and their non-offending loved ones. They also receive calls from behavioral health units, intensive care units, oncology, and St. Elizabeth physician's offices.
- KCADV created a position designed to address substance use/mental health issues in member programs. The position will provide training, technical assistance, product development, and systems advocacy related to substance use, mental health, and systems involvement.
- KCADV entered into an agreement to work with the Adult Substance Use Treatment and Recovery Services, Division of Behavioral Health to provide 10 peer support specialists that will provide direct substance use treatment activities to survivors in member programs.
- Conducted a series of focus groups with survivors to identify the level of systems involvement for survivors of violence and their risk for the removal of their children due to domestic violence
- Incorporation of the Batterer Intervention Provider program into coalition office activities
- KCADV began collecting data regarding survivors who have had their children removed due to domestic violence and lack of understanding of the dynamics of domestic violence
- Requested regulation changes to allow member programs to be able to administer emergency medication such as Narcan/Naloxone
- Selected statistics:
    - 1716 people were served through emergency shelter services
    - 700 Ready-to-Work students
    - 1.1 million dollars in federal refunds returned to Kentucky families through free tax preparation

- 22,388 survivors received non-residential services through 15 member programs
- 4,525 women, men, and children were provided with emergency shelter and transitional housing
- 2,255 training opportunities were offered through 15 member programs and the coalition office

Q. Health Access Nurturing Development Services (HANDS)

The Health Access Nurturing Development Services (HANDS) program is a voluntary home visitation program for new and expectant parents, as well as a recent expansion to parents who are parenting other children. Services can begin during pregnancy or any time before a child is 3 months old. Families begin by meeting with a HANDS parent visitor who will discuss any questions or concerns about pregnancy or a baby's first years. Based on the discussion, all families will receive information and learn about resources available in the community for new parents. Some families will receive further support through home visitation. HANDS is supported by federal Medicaid and state Tobacco Funds, and operates statewide as a free service program. The program is housed in the local health departments in all 120 counties in Kentucky. The primary goals of the HANDS program include:

- Healthy pregnancies and births
- Healthy child growth and development
- Healthy, safe homes
- Self-sufficient families

R. Johnson County Community of Hope

The Johnson County Community of Hope (JCCOH) was developed with the insight and guidance of Judge Janie McKenzie-Wells and Susan Howard, Eastern Mountain Service Region Administrator, after Casey Family Programs expressed interest in supporting a rural and community based initiative featuring a substance abuse treatment component that would be responsive to the needs of Johnson County and help strengthen families. The newly created JCCOH's vision was to build a community based set of services and interventions that would serve to reduce the number of children in OOHC and reduce the number of dependency, neglect, and abuse cases across the county. A steering committee was created and worked to develop and coordinate a substance abuse program within the community. After almost a year of work and planning, the committee devised a three-prong approach to meeting the needs of the community. In conjunction with the substance abuse program, a mentoring sub-committee was created to establish a program of that provides skills and resources to the women involved in the JCCOH substance abuse program, in addition to others within the community. Weekly sessions include topics such as life skills, ages and stages, reality life skills, health care and supportive services, child's play, gardening, financial aid and scholarships, budgeting, quilting and crocheting, CPR and first aid, needs of the child, Darkness to Light (sexual abuse awareness and prevention training), self-defense, crock pot cooking, and art classes. These sessions are based upon a needs inventory developed by the committee and distributed to the participants by the substance abuse program peer mentors. As needs are identified within the population receiving services, the mentoring committee strives to meet the needs by the coordination of sessions targeting their specific requests. All speakers and presenters are from the local community. They present within their area of expertise. (These services continue to occur, however, they are now being held at the JCCOH substance abuse treatment location as opposed to the Johnson County Public Library. This change in location has greatly increased attendance and interest in the sessions.) Referrals to the program are primarily received from DCBS, as well as family court and self-referrals. During 2018, 101 referrals were made to the program.

Throughout calendar year 2018, JCCOH has continued to use the three-prong approach to meeting the needs of the community. The JCCOH steering committee held quarterly meetings throughout 2018 with the last meeting held on November 30, 2018. The governing board, along with key steering committee members, have worked to strategically expand membership and to generate interest in JCCOH.

As mentioned in the last submission, JCCOH was awarded the Regional Partnership 4 Grant. This 5 million dollar grant has allowed JCCOH/Mountain Comprehensive Care to replicate the Community of Hope model in both Martin County and Floyd County. The program is proud to report that Communities of Hope services are now up and running in both counties and both are very successful. Floyd County Community of Hope clients are transported to the JCCOH office, where they receive all services. The Martin County Community of Hope has been successful and grown so rapidly that Mountain Comprehensive Care is currently building the Martin County Community of Hope its own facility.

Although JCCOH did not receive any Casey Family Programs funding for 2019 (and will be receiving none in the future), the Regional Partnership 4 Grant will allow JCCOH to continue to provide services and improve outcomes for families for at least the next four years.

The JCCOH substance abuse program continued to offer treatment and peer support services five days a week throughout 2018. At the November 2018 steering committee meeting it was reported that JCCOH had 35 women participating in the program. This number fluctuates as some women leave the program and new referrals are made. Approximately 22 new referrals have been made during this reporting period. Several participants have been able to develop payment schedules for fines, resolve bench warrants, and paid child support or arranged to make payments. Six children found permanency with relatives, eight children exited care to relatives, four children were placed with their fathers, 16 children returned to their mothers, four children had termination of parental rights, six mothers obtained supervised visits, and five participants graduated from the program.

During 2018, JCCOH staff collaborated with Johnson County DCBS staff throughout April for Child Abuse Prevention Month activities. JCCOH Employment Specialist Linda Howard assisted eight participants in obtaining employment. Special events were held at Valentine's Day, Easter, Fourth of July, Halloween, Thanksgiving, and Christmas where the participants and their children enjoyed dinner, activities, and quality time together. These opportunities did not count as regularly scheduled visits for those participants who have limited contact with their children and were eagerly anticipated by the participants. Lastly, the substance abuse program continued to conduct a Narcotics Anonymous group for the participants.

The JCCOH hired a case manager in 2018. Thorough the course of the year the case manager assisted 21 clients in obtaining housing. The case manager assisted several participants in paying electric bills and obtaining needed household items such as beds for the participant and their children.

As part of the Education Committee, the High Expectations Coordinator serves at-risk youth in the Johnson County School System. At-risk youth are defined as possibly re-entering foster care, having extreme acting out behaviors, unmet mental health needs, truancy, substance abuse, social isolation, and the inability to concentrate on classroom issues among others. The overarching goal of the High Expectations program is having fewer children in foster care. To this end, the High Expectations Coordinator coordinates the educational program for the at-risk youth, provides service coordination, strengthens partnerships between the school, home, and the community, provides counseling to individual students, and works to build strong families.

During calendar year 2018, the High Expectations Coordinator received 137 referrals and provided services to 109 students. The High Expectations Coordinator has current caseload of 14 students. Key activities for the High Expectations Coordinator during 2018 included attending and participating in the following: regular meetings with school principals and resource directors; meetings with students to discuss grades and progress; meetings with cabinet social workers and families to discuss active cases; student conferences; and regularly scheduled meetings with school-based therapists to discuss student issues, progress, and concerns.

S. Kentucky Center for School Safety

Kentucky's schools focus on providing a warm culture and climate for both students and staff that is conducive to high levels of productivity and outstanding academic performance. In today's society, school safety is a daily issue that ranges from classroom management to school incident command for crisis situations. The Kentucky Center for School Safety (KCSS) staff is committed to providing training, resources, information, and research to Kentucky's schools.

KCSS's belief is that school culture improves when a school-wide prevention plan consistently addresses the needs of all students to encourage a safe and healthy learning environment. The mission and scope of work for KCSS demanded that a statewide collaborative effort be undertaken. This collaborative partnership brings together a dynamic blend of experience and expertise in project management and the provision of training and technical assistance to education, human service and justice professionals, teacher preparation, applied research, electronic communication, and school and community needs assessment. The KCSS Board of Directors approved the following formula for the distribution of funds to all Kentucky school districts:

<u>Fiscal Year 2018</u>

- Amount to be appropriated: $10,373,300
- KCSS Board allocated $1,100,000 for the Center's Activities (Eastern Kentucky University, Murray State University, Kentucky School Board Association).
- Each school district received $9,278.300; minus $20,000 base for each district ($3,500,000 total)
- Each school district received $9.56 per student based upon current district's Average Daily Attendance (ADA) of 605,555.

KCSS operates statewide through a variety of major initiatives and programs. KCSS works collaboratively with various service organizations, including Kentucky Educational Collaborative for State Agency Children (KECSAC), Department of Juvenile Justice (DJJ), Department for Mental Health, DCBS, and KDE. Its scope of work requires a statewide collaboration of resources. Therefore, to date, KCSS collaborates with the Kentucky School Boards Association, Murray State University, and the University of Kentucky. Additionally, Kentucky School Boards Insurance Trust works with KCSS to provide the services of loss control specialists for schools/districts.

On July 13, 2018, Governor Bevin issued an executive order reorganizing various education boards and councils. The Governor abolished KCSS (KRS 158.442 and KRS 158.443). The KCSS Board of Directors was reduced from twelve members to eleven members. DCBS is no longer a required member.

KECSAC assists local education agencies to provide and assure high-quality educational support services through a collaborative delivery system involving the KDE, DJJ, community based services, mental health services, developmental disabilities and addiction services, and private and public child and youth care

programs. KECSAC provides administrative services, professional development, and leadership in an efficient and cost-effective manner that complies with state education reform initiatives and other applicable state and federal mandates. KECSAC provides a comprehensive evaluation of the delivery of educational services to state agency children including the administrative process, service delivery, program monitoring, and outcomes.

Throughout the year, KCSS is available to schools across Kentucky. KCSS, KDE, and KSBA collaborate to provide safe school assessments to any school in Kentucky. The voluntary assessment can enhance the school's learning environment by examining climate and culture. KCSS oversees and distributes safe schools' funds to each local school district, the Kentucky School for the Blind, and the Kentucky School for the Deaf. A safe school assessment is a service provided by the KCSS at no cost to the school or district. The KCSS staff takes great pride in being able to fully accommodate superintendents, principals, and other school personnel as well as parents and community members whenever they contact the center for assistance.

Additionally, KCSS is working closely with all schools statewide to address training for gun violence, safety, and bullying for students and staff. Due to the increase of gun violence in the school system, KCSS produced brochures to assist school staff to identify indicators of violence and areas of safety improvements. Current barriers to this initiative are fiscally based.

An 11-member board of directors, appointed by the governor, guides its work. The board meets on a quarterly basis and communicates as needed via email and emergency meetings. Prior to July 2018, the Commissioner for DCBS had a seat on KCSSs Board of Directors. A Child Protection Branch program specialist sits on the board as a designee for the Commissioner. Other board of director members represent circuit court, Division of Mental Health, school superintendents, KDE, DJJ, Kentucky Education Support Personnel, Kentucky Association of School Councils, school principals, school boards, school bus drivers, and teachers.

It has been beneficial for a representative from the Child Protection Branch to sit on the board of directors for KCSS. The Child Protection Branch reviews and provides consultative services for specialized investigations and support services throughout the state that include child protective service (CPS) investigations involving schools. As a member of the board of directors, the Child Protection Branch is able to educate board members on DCBS investigation-related policy and advocate for frontline staff who conduct CPS investigations in school settings or on school employees. The Child Protection Branch has also been able to provide more valuable consultation regarding school investigations to frontline staff because of the collaborative relationship developed with respective agencies.

Changes implemented by the Executive Order will have minimal fiscal impact. The board will see a reduction in size, which could lead to nominal savings.

T. Kentucky Children's Health Insurance Program

The Kentucky Children's Health Insurance Program's (KCHIP) mission is to promote responsible partnerships between families and community agencies in order to establish and maintain access to health insurance for Kentucky's eligible children. A statewide program, KCHIP collaborates with various organizations and agencies in order to ensure quality access to care for enrollees. KCHIP contracts with DCBS and Benefind to determine eligibility for potential enrollees. KCHIP also works closely with local

health departments to provide age-appropriate screenings for enrolled children and with the Department for Public Health to provide vaccines for eligible enrollees.

All KCHIP enrollees receive a benefit package that provides comprehensive coverage to meet children's physical and mental health needs. KCHIP covers health check-ups, screenings, prescriptions, medications, immunizations, physician office visits, hospital care, mental health, allergy injections, substance abuse, and other medically necessary services.

Additional information about KCHIP can be found at https://chfs.ky.gov/agencies/dms/Pages/default.aspx.

Title XXI and state general funds fund KCHIP. Services are available statewide. KCHIP uses quality standards, performance measures, and information and quality improvement strategies to assure high-quality care for KCHIP enrollees. Data is collected to maintain fiscal resources and proper administration.

Per Affordable Care Act requirements, children below 138% of the federal poverty level (FPL) (P5 status codes) in the KCHIP Expansion Program were transitioned into Medicaid effective 1/1/2014. Per Centers for Medicare and Medicaid Services (CMS) direction and funding purposes, this group of children continues to be counted with the number of children served in the KCHIP Expansion Program. Per federal fiscal year 2018 final reports, CMS 64 EC-21E (Expansion) and CMS -21E (KCHIP), 103,244 children were served during federal fiscal year 2018. KCHIP operated within its forecasted expenditures; averted the elimination of any services; and maintained enrollment levels without instituting a waiting list, lowering eligibility, or reducing benefits.

As stated in the Department for Medicaid Services' contract, the MCOs (Passport Health Plan (PHP), Humana Care Source, WellCare, Aetna Better Health of Kentucky, and Anthem) must implement and operate a comprehensive quality assessment/performance improvement (QAPI) program that assesses, monitors, evaluates, and improves the quality of care provided to its members. The MCOs must provide QAPI program status reports to the Department for Medicaid Services quarterly. The QAPI program is reviewed annually for effectiveness with a final report submitted to the Department for Medicaid Services. The MCOs are required to implement steps towards improving performance goals for the Kentucky Outcomes Measures and HEDIS measures. The MCOs conduct annual surveys of member and providers' satisfaction with the quality of services provided and their degree of access to services by participating in the Consumer Assessment of Healthcare Provider and System (CAHPS) Survey.

The MCO's 2018 CAHPS survey indicates that overall utilization of health services by KCHIP recipients continue to remain high; access to needed care and specialized care do not appear to be major problems for KCHIP recipients; recipients are largely satisfied with their experiences of care; and evaluations of health care providers, health services, and KCHIP-related health plans are generally positive.

During the reporting period, Kentucky continued to coordinate with a statewide managed care system to expand outreach efforts and continue to increase awareness of the program at the community level. Eligibility passive renewal process was instituted in July 2015, which allowed eligibility to be recertified electronically via a match with the federal hub. Therefore, increases in enrollment trends are expected to continue. KCHIP's ongoing goals are to continue to increase retention efforts, maintain current level of outreach, and to continue to increase enrollment.

U. Kentucky Education Collaboration for State Agency Children

KECSAC is a statewide collaborative that works with state agencies, school districts, and local programs to ensure that state agency children (SAC) receive a quality education comparable to all students in Kentucky. SAC are all children and youth placed in programs contracted, funded, and/or operated by DJJ, CHFS (which includes DCBS), and DBHDID in the state of Kentucky.

KECSAC is committed to the belief that all children can learn and have a right to quality education. KECSAC protects and assures this right by accessing resources and providing support to programs that educate SAC. Those children who do not receive an education of quality cannot realize their greatest potential. KECSAC believes these goals are achieved through the process of interagency collaboration. To accomplish the mission, all members of this statewide partnership must exemplify and publicly promote collaborative relationships with our partners and other associates. KECSAC staff meets quarterly with the Interagency Advisory Group, which consists of the following collaborative partners: DJJ, DCBS, DBHDID, KDE, and the College of Education at Eastern Kentucky University (EKU). KECSAC is largely funded through state general funds.

KECSAC distributes the SACs fund to programs that serve SAC in educational settings. The funds must be used by educational programs in state educational districts to provide smaller student to teacher rations (10:1) and to provide extended school days during the academic year (an additional 33 educational days are required in order to receive SAC funds). In addition to providing the funding for educational programs that serve SAC, KECSAC also provides training to educators and administrators in the programs. Annually, KECSAC provides professional development opportunities for educators through the At-Risk Conference and *Teaching in Action Series*. Professional development events are free to KECSAC program members and consistently rank very well in evaluations from attendees.

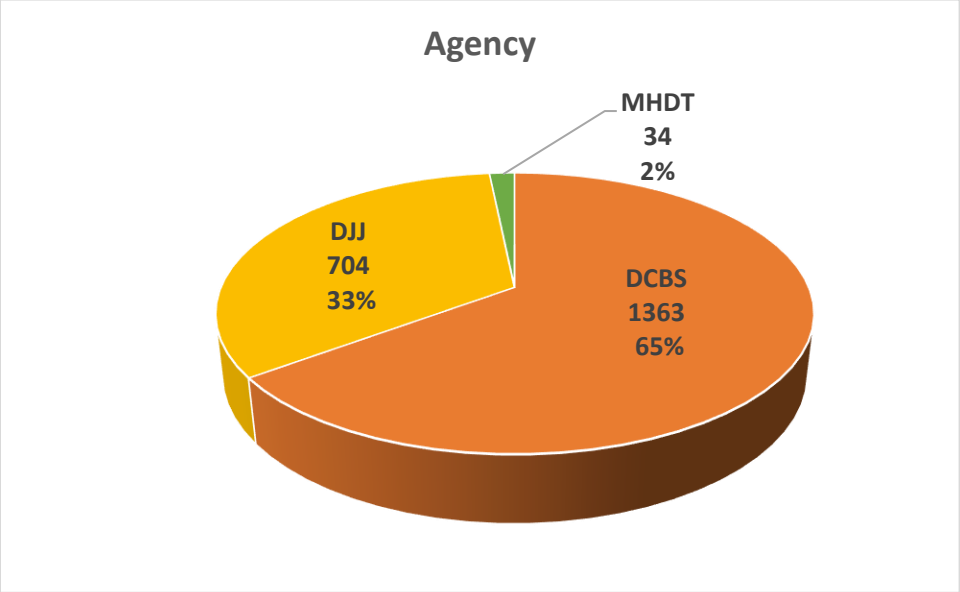
Currently, KECSAC operates 83 educational programs in 52 school districts. Forty of these programs contract with DCBS. In KECSAC schools, there are 288 full-time certified on-site educators. Of these, 192 are full-time exceptional education certified, 11 are full-time emergency certified educators, 63 are full-time administrators, 150 are full-time teaching assistants, and 83 are other support staff.

Program improvement specialists use a tool, which is aligned with Kentucky's standards and indicators, to audit the educational services provided the youth in state care. Specialists observe classrooms, review prepared evidence, as well as interview the school administrator, program administrator, teacher, and students. If needed recommendations for improvement are communicated to the program, a follow-up visit is scheduled. Attention is also paid to progress made from the previous year's report to ensure programs are continuing to meet standards and improve curricula. In 2016-2017, every program was visited at least once to ensure youth are receiving a quality education.
KECSAC services include:

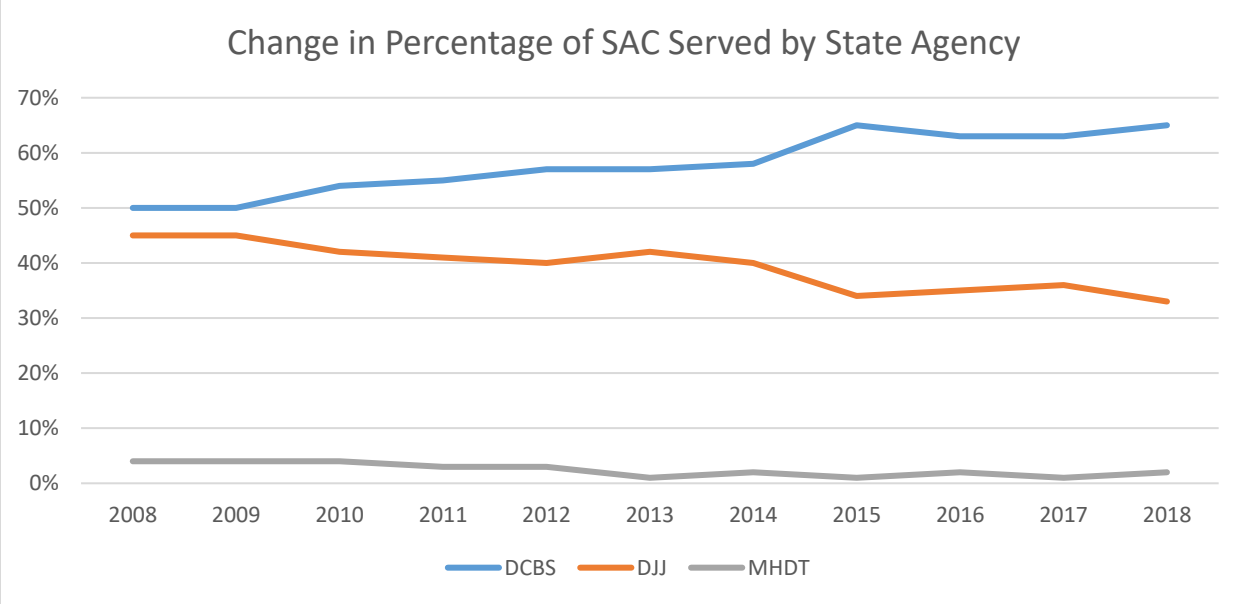
- Distributing SACs funds to school districts for local programs serving SAC.
- Providing program improvement support through annual visits completed by program improvement specialists.
- Providing training and technical support to SAC and other educators and administrators.
- Providing facilitation services and mediation support to districts and programs when needed to settle disputes between school districts and programs.
- Publishing a quarterly newsletter, *The Collaborative*; annual census report; annual program directory; and quarterly and annual progress reports.

- Reviewing and recommending revisions to KECSAC regulations and statutes.

As illustrated below, the total number of children served in KECSAC programs in 2018 was 2,101. DCBS children comprised 1,363 or 65% of the total population served.



The number of children from DCBS being served by KECSAC programs has been increasing since 2006. This rise may the result of the court system attempting to serve more children through community resources and divert children from entering into DJJ's care.



Senate Bill 200 became effective in July 2015. This legislation affects youth who have a status, misdemeanor, or Class D felony offense complaint filed against them. In addition, this legislation makes major changes to the policies and practices in the Administrative Office of the Courts and DJJ. The legislation makes minor changes to the policies and practices in DCBS, DBHDID, and KDE. The legislation

also creates new responsibilities for local agencies that are named representatives of the newly established Family, Accountability, Intervention, and Response teams. This legislation may result in fewer children being served by KECSAC programs in the future.

V. Kentucky Partnership for Families and Children, Inc.

Kentucky Partnership for Families and Children, Inc. (KPFC) is a statewide, non-profit, family organization that was founded in 1998. A family organization is an organization that has over 51% parents/primary caregivers raising children with behavioral health challenges. KPFC has seven permanent employees and three part-time employees; 80% of the staff is parents that have raised, or are raising, children with behavioral health challenges and three staff members are adults that received services for children's behavioral health disabilities as children. KPFC supports five different programs: early intervention for families raising young children ages 0 to 5 at risk of social-emotional delays; transitional-age youth leadership; family and youth peer support specialists; family and youth network building; and training for parents, teens, and provider partners. KPFC has collaborated with DBHDID on three Children's Mental Health Initiative Cooperative Agreements that focus on expanding and strengthening Kentucky's system of care for children with behavioral health challenges. KPFC receives funds from DBHDID, FRYSCs, KDE, fees for service for training, fundraising, and donations.

KPFC staff, parent leaders, and transitional-age youth leaders participate on multitude of state-level and regional-level committees:

- Statewide interagency council subcommittees;
- University of Louisville's Project SAFESPACE in partnership with DCBS and DBHDID;
- Kentucky Center for Instructional Discipline;
- Parent/professional conferences planning teams;
- CJA Task Force;
- Transition-Age Youth Launching Realized Dreams;
- Kentucky Interagency Transition Committee; and
- Strengthening Families Leadership Team.

KPFC staff, parent leaders, and transitional-age youth leaders also provide trainings and workshops on the following topics across the state for professional groups as well as for foster/adoptive parents and teens: reactive attachment disorder, surviving challenging behaviors, better understanding ADHD/bipolar disorder/etc., bridges out of poverty, and youth mental health first aid. KPFC's board also consists of 51+% parents and agency representatives from child welfare, courts, education, private childcare, etc.

KPFC has observed an increase of CMHCs hiring family and youth peer support specialist to provide peer services. Possible reasons for this increase may include that these services are Medicaid billable, they have effective treatment outcomes, and they are provided at lower cost than higher-level services. Future goals for KPDC include continuing to move forward in creating KPFC satellite offices to provide community-level peer support services to families across the state. Barriers that KPFC is currently experiencing include the inability to bill Medicaid for services, lack of office space in various locations across the state, and lack of finances to support peer support positions.

W. Kentucky Strengthening Families

Kentucky Strengthening Families (KYSF) represents a multi-disciplinary partnership of over 20 national, state, local, public, and private organizations dedicated to embedding six research-based protective

factors into services and supports for children and their families. Supporting families is key strategy for promoting school readiness and preventing child abuse and neglect. All families experience times of stress, and research demonstrates that children grow and learn best in families who have the supports and skills to deal with those times. By supporting families and building their skills to cope with stressors, we can increase school readiness and reduce the likelihood abuse will occur in families. KYSF uses a nationally recognized strategy: Strengthening Families: A Protective Factors Framework, which is coordinated nationally by the Center for the Study of Social Policy. In April 2017, KYSF began to promote the complimentary Youth Thrive Protective Factor Framework for youth ages 9-26 years old. In 2018, Youth Thrive was combined with KYSF into a 2-day training event: Family Thrive.

The vision of KYSF is that all Kentucky children are healthy, safe, and prepared to succeed in school and in life through families that are resilient, supported, and strengthened within their communities. The mission of KYSF is to strengthen families by enhancing protective factors that reduce the impact of adversity and increase the well-being of children and families through family, community, and state partnerships. KYSF is supported by the Governor's Office for Early Childhood through funds from the Race to the Top/Early Learning Challenge Grant and the Tobacco Settlement Dollars administered by the Department for Public Health. KYSF is a statewide, long-term initiative, with ten-year goals.

KYSF protective factors include: 1) parental resilience: families bounce back; 2) social connections: families have friends that they can count on; 3) knowledge of child development: families learn how their children grow and develop; 4) concrete support in times of need: families get assistance to meet basic needs; 5) social and emotional competence of children: families teach children how to have healthy relationships; and 6) nurturing and attachment: families ensure children feel loved and safe.

Kentucky Youth Thrive is a lens for assessing current efforts and making changes to the policies, programs, training, services, partnerships, and systems that affect young people, particularly those involved in public systems. It uses the latest science to drive support for services based on five protective factors that promote well-being for youth: youth resilience; social connections; knowledge of adolescent development; concrete support in times of need; and cognitive, social, and emotional competence.

The KYSF conceptual framework involves building research-based protective factors around young children by working differently with their families across all child- and family-serving organizations and systems. This approach includes aligning systems with protective factors, using data driven decision-making, marshaling leadership, and making policy and systems changes on multiple levels.

In 2013, the Governor's Office for Early Childhood and the Department for Public Health convened a group inclusive of many organizations that touch families to explore the implementation of the KYSF framework. These organizations represented by the leadership team made a commitment to embed the protective factors in the daily practice of government and community-based programs. In January 2014, the leadership team developed a strategic plan to move the KYSF initiative forward in the Commonwealth and has revised this plan in 2015, 2016, and 2017. Workgroups have created tools to assist partnering agencies and programs with embedment of the KYSF Protective Factor Framework into programs. These tools include a website, marketing materials, child care training, theory of change, level of involvement tool, program assessment tools, as well as Parent Café training and toolkit.

During 2018, the KYSF Leadership Team met bimonthly with workgroups including Family Informed; Training and Technical Assistance; Evaluation; Partnerships and Integration; and Communication.

Representatives from over 20 partner organizations, departments, and agencies make up the Leadership Team.

Two Regional Leadership Teams were created in 2018: one in Northern Kentucky and one in Western Kentucky. The regional team membership is representative of similar partners as the state team. In the fall of 2018, 189 people attended the first annual KYSF Summit in Paducah, Kentucky. Both regional teams are securing grant funding for projects related to KYSF. These teams meet bimonthly and representatives from the regional teams attend the state meeting. Family Thrive Training took place in Frankfort and Covington in 2018. Currently the program has 60 master trainers for Family Thrive.

In 2018, the Leadership Team approved combining the youth thrive protective factors into the existing KYSF Framework. This allows each partner to use the framework with families and young people. Some of accomplishments of the program in 2018 include the following:

- Trained 210 individuals in hosting Parent and Youth Cafes
- Marketing materials developed:
    - Family Thrive Action Guide
    - One Page Framework Sheet
    - Rack Cards for Parents
    - Parent and Youth Café Cards (Western Team)
    - Online Café Collective Group started (Western Team)
    - ACEs Infographic
    - How Systems work together infographic
- Trained 60 new Family Thrive Trainers
- Western Kentucky Summit (189 people in attendance)

KYSF has received technical assistance from the Center for Study of Social Policy and CDC Essentials for Childhood Technical Assistance system for non-grant funded sites. KYSF co-chairs participated in the National Together for Families Conference in Cleveland, Ohio and received technical assistance from the National Family Support Network on the Standards of Quality for Family Support.

Protective Factor Surveys and Café Evaluations for Parents and Youth are being collected in the regions. Training data and collective impact data along with self-assessments for service providers are being collected and will be analyzed in 2019. Family engagement best practices will be identified through the Preschool Development Grant in 2019.

Proposed future direction for the program includes:

- Expansion of regional teams
- Training specific to regions
- Regional Summits
- Parent and Youth Café Expansion
- Social media presence

X. Michelle P. Waiver Program

The Michelle P. Waiver is a home and community-based waiver under the Kentucky Medicaid program developed as an alternative to institutional care for individuals with mental retardation or developmental disabilities. It was designed so that people who were placed in institutions could return to or remain in their communities. The Michelle P. Waiver allows individuals to remain in their homes

with services and supports. Adults and children alike are eligible for the program as long as the meet the criteria for eligibility. In order to qualify, recipients must have intellectual disabilities (mental retardation) or developmental disabilities that meet the requirements for residence in an intermediate care facility or a nursing facility. Recipients must also meet Medicaid financial eligibility requirements.

Michelle P. Waiver services include:

- Case management
- Adult day training
- Supported employment
- Community living supports
- Behavior supports
- Occupational therapy
- Physical therapy
- Speech therapy
- Respite
- Homemaker service
- Personal care
- Attendant care
- Environmental/minor home adaptation
- Adult day health care

Y. Multidisciplinary Commission on Child Sexual Abuse

The Kentucky Multidisciplinary Commission on Child Sexual Abuse (KMCCSA), staffed by the Office of the Attorney General, is tasked with preparing and issuing a model protocol for local MDTs regarding investigation and prosecution of child sexual abuse and the role of the CACs on MDTs (KRS 431.660). The model protocol provides an extensive description of each team member's role and responsibility. The statute requires protocols to be developed in each county or group of contiguous counties by the team (KRS 431.600). In addition, KMCCSA must review and approve protocols prepared by MDTs.

In the fall of 2015, KMCCSA presented the revised MDT protocol at the Prevent Child Abuse Kentucky Conference, the Kentucky Victim Assistance Conference, and the 17th Annual Ending Sexual Assault and Domestic Violence Conference. In addition, KMCCSA collaborated with the Kentucky Association of CACs and the regional CACs to present training on the protocol across the state. All local MDTs were asked to submit a revised local protocol by April 1, 2016. Since then, KMCCSA has reviewed and approved the protocols from nearly all local MDTs. Local MDTs continue to update their protocol to the newly revised model that was effective January 2016.

Each local MDT is charged with completing and submitting the mandatory data collection tool by the end of January each year. In turn, KMCCSA is responsible for compiling and adopting an annual report reflecting the work of KMCCSA and local MDTs.

KMCCSA has no monies, per se. The Office of the Attorney General pays for administrative fees that are incurred when this board meets. In 2017, CVTF awarded a minimal amount of money to the commission for any identified needs or materials. The Commission did not utilize the funds, thus CVTF awarded the Commission $5,000 for fiscal year 2019.

Z. Office for Children with Special Health Care Needs

The Office for Children with Special Health Care Needs (OCSHCN) provides gap-filling specialty and subspecialty pediatric care to medically underserved children as well as enabling public health services statewide. Created in 1924 by the state legislature to provide treatment to children with orthopedic conditions across the state, OCSHCNs clinical services have since expanded to include treatment and care coordination for a variety of severe and chronic conditions. The agency endeavors to create a comprehensive, quality system of care for Kentucky's children with special health care needs, which is defined as children birth to age 21 who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. In addition to administering the state's title V Children with Special Health Care Needs medical services program, OCSHCN provides special services to address health care needs of children involved with the child welfare system and a population-based Early Hearing Detection and Intervention (EHDI) program to ensure the assessment of hearing in newborns statewide.

OCSHCNs mission is to enhance the quality of life for Kentucky's children with special health care needs through direct service, leadership, education, and collaboration. Services are family-centered and community-based with access to specialty providers coordinated through 11 regional offices. The agency's website is located at http://www.chfs.ky.gov/OCSHCN, where a directory of services lists programs available in all areas of the state.

Specialty medical clinics and programs are available for the following conditions:

- Asthma (severe) – no clinic, but case management and financial assistance are provided to families as needed
- Cerebral palsy
- Cleft lip and palate
- Craniofacial anomalies
- Cystic fibrosis – no clinic, but case management and financial assistance are provided to families as needed
- Eye – combination of onsite clinics, case management, and financial assistance in some areas
- Hand – no clinic, but case management and financial assistance are provided to families as needed
- Heart
- Hemophilia (pediatric and adult) – financial assistance only
- Juvenile rheumatoid arthritis – no clinic, but case management and financial assistance are provided to families as needed
- Neurology/seizure
- Neurosurgery
- Orthopedic
- Otology – combination of onsite clinics, case management, and financial assistance in areas where patients are seen in the private office
- Plastics/reconstructive surgery (part of cleft lip and palate and craniofacial anomalies)
- Scoliosis
- Spina bifida – no clinic, but case management and financial assistance are provided to families as needed

As a public agency within CHFS, OCSHCN shares a statewide parent organization with DCBS, Medicaid, and other important social service and health programs. Over the course of 95 years, OCSHCN has developed formal and working relationships with a variety of programs providing services to children. The number of director providers in the network for clients is in the hundreds. In addition to direct care provided in specialty clinics, children with eligible diagnoses may receive care coordination services from registered nurses. Depending on the individual needs of the child, this may involve varied activities such as:

- Advocating and helping patients and families understand their current health status and educating them on what they can do to improve it;
- Linking families with resources and providing cohesion among other professionals of the health care team to efficiently and effectively accomplish goals;
- Attendance at school meetings; or
- Home visits for individual health planning meetings with DCBS social service workers.

OCSHCN employs family consultants and social workers who assist families to access outside services or help with overcoming barriers to optimum care. A Family-to-Family Health Information Center program places parent-organized resource centers within OCSHCN clinics and establishes a network of parents who provide peer support. Critical partnerships exist with the Home of the Innocents, a PCC facility where Louisville therapy staff (physical therapists and occupational therapists) have access to a state-of-the-art therapy pool. Universities provide expertise by way of administering the Lexington and Louisville Hemophilia Treatment Centers. A number of specialty providers have become active with OCSHCN due to their affiliations with Kentucky's teaching hospitals. In addition, the Louisville OCSHCN office is a point of entry for Kentucky's Early Intervention Programs' Kentuckiana Regional Planning and Development Agency region.

Through a formal needs assessment process (pursuant to the Maternal and Child Health Title V Block Grant), agency strategic planning, and ongoing interagency communication, OCSHCN works with state, local, and regional medical providers to ensure that services are available to meet the needs of all Kentucky children with special health care needs. In addition to involvement on a case level, several OCSHCN staff are active on boards and councils (such as Kentucky Council on Developmental Disabilities, State Interagency Council for Services and Supports to Children and Transition-Age Youth, etc.) that further the agency's mission. OCSHCN also receives input from formal stakeholder advisory groups of youth and parents.

Agency leadership continues to feel that the partnership with DCBS is a vital one, and remains consistent with OCSHCNs mission. As a Title V (Maternal and Child Health services) agency, OCSHCN prepared a five-year needs assessment in 2015, results of which guide the direction of services, especially with regard to any new or expanded programs. Priorities for the years 2016-2020 include transition to adulthood, improving access to care and services, ensuring adequate insurance coverage, and enhancing agency data capacity. In light of Kentucky selecting transition services as a Title V National Performance Measure, emphasis will be placed on ensuring services for youth health care transitions to adult care with the child welfare population, those youths enrolled in OCSHCN clinical programs, and others served by the agency.

<u>Early Hearing Detection and Intervention (EHDI) Program</u>
Kentucky's EHDI program oversees hearing screening at birth hospitals that deliver more than 52,000 births annually across the Commonwealth. Ninety-eight percent (98%) of all live births received a

newborn hearing screening prior to discharge. In addition to providing technical assistance to hospital hearing screening programs, EHDI program staff work with clinical audiologists and Part C providers to ensure that infants not passing their hospital-based newborn hearing screening are able to receive diagnostic assessment of hearing and, if necessary, appropriate early intervention (EI). A memorandum of agreement with First Steps (FS) created a collaborative agreement with Part C to provide audiologic evaluation for all FS-eligible infants and toddlers prior to onset of FS services, and a separate memorandum of understanding with DCBS provides for OCSHCN to fulfill the role of primary audiology provider for children in the custody of DCBS. The EHDI program sends letters to infant's primary care physicians informing them of the infant's risk of hearing loss as well as when infants were diagnosed with hearing loss.

Foster Care Support Programs

Medically Complex: OCSHCN continues to collaborate with DCBS in teaming DCBS social service workers with OCSHCN nurses to visit medically complex foster care children once a month to address their medical needs. This program has an ongoing population of approximately 136 high-risk or "medically complex" children. The DCBS social service worker maintains his/her professional obligation for the medically complex foster care child's care and well-being. The OCSHCN nurse reviews medical records, assists with meetings of the individualized health plan team, assists DCBS with specialty provider consultation, and for the medically complex foster care children, provides guidance and ongoing education for the foster parents as needed. OCSHCN is participating with the nine DCBS service regions to provide services to medically complex foster care children statewide. Currently, all 120 Kentucky counties are able to receive services.

Nurse Consultant Inspectors

OCSHCN nurse consultant inspectors housed in DCBS regional offices are full-time resources for child welfare personnel, children, families, and foster care providers before, during, and after a child's stay in OOHC. This service includes children not considered medically complex, including over 8000 in OOHC, and many more who are at risk of removal and placement. Expertise is currently provided in all DCBS service regions. Roles of nurse consultant inspectors include:

- Interpretation of medical records and reports;
- Consultation to social service workers and foster care families on medical issues;
- Home visitation when appropriate for other foster care children for assessment purposes;
- Teaching and education of foster families and social workers on medical procedures, treatments, and expected outcomes;
- Assurance of the maintenance of updated Medical Passports;
- Care coordination of medical, dental, and behavioral health services (including provision of important drug interaction information);
- Tracking the utilization of health services, including prevention and wellness programs; and
- Consultation on medical issues for children at risk for OOHC.

Hemophilia Treatment Centers

Hemophilia treatment centers (HTCs) in Lexington and Louisville assist with factor products and other related medications needed to manage bleeding episodes. Each case is individual and must be reviewed before any determination can be made. Families needing assistance complete an application process and must meet eligibility criteria. OCSHCN is always payer of last resort.

Transition Program

OCSHCNs Transition Program continues helping young people move from school to work, from pediatric to adult health care, and from living at home to independent living. OCSHCN nurses and social workers utilize an age appropriate transition checklist to work closely with young people and their families to help them plan for the future. OCSHCN nurses, social workers, and family consultants help families find resources, facilitate communication, and support parents as they seek services for their children. OCSHCN nurses work with youth and families and collaborate with local adult providers to assist youth to transfer to an adult health care provider at age 18 when the youth becomes an adult.

Parent and Youth Involvement

The Youth Advisory Council (YAC) is comprised of youth from across the state with a variety of physical and mental disabilities. Most of the council members receive services from OCSHCN. This is a diverse group of youth, and provides youth with disabilities a voice.

The Parent Advisory Council (PAC) is comprised of parents of children with disabilities. Most of the council members have children that have received services from OCSHCN. This is a diverse group representing several regions of the state and provides a means for parents to provide input into OCSHCNs services.

OCSHCNs Family to Family Health Information Center initiative has created a network of families trained to support other families, encourage families to become involved in efforts that will lead to reduced barriers to care, and build family capacity to make informed choices and be involved in decision making at all levels.

Data

During 2018, OCSHCN provided specialty medical services to 8,856 patients. Of the total number of patients seen, 72% had Medicaid/KCHIP, 20% had private insurance, and 8% had no insurance. OCSHCN accepted 2,365 new patients and discharged 2,242 patients; 17,151 visits were recorded.

During 2018, OCSHCN's EHDI program received 51,860 hearing screening report forms. Failing the newborn hearing screening is considered a risk factor for hearing loss, according to the Joint Committee on Infant Hearing. Of the infants screened, 1,827 failed on one or both ears; an additional 998 presented as pass/pass on the hearing screen but had other risk factors for late onset or progressive hearing loss documented. Therefore, the total number of infants at risk for hearing loss was 2,825. This is a decline from last year.

During 2018, OCSHCN medically complex nurses made 1,441 home visits. At any one point in time, the total number of medically complex foster children served by the agency averages between 121-138. Approximately 199 new medically complex referrals were received during the reporting period.

During 2018, OCSHCN nurse consultant inspectors residing in DCBS offices provided the following services on behalf of children in the child welfare system (services outnumber referrals, as many cases require more than one type of service):

Referrals received: 230
Home visits made: 1,441
IHP reviews: 303
Medical record/report reviews: 1,070
FTMs/5-day conferences: 20

Sub specialty referrals: 229
Medical passports reviewed: 1,399

OCSHCN continues to feel that the agency is uniquely poised to assist DCBS in meeting the health needs of children involved in the child welfare system, who are by their nature medically underserved. Medically complex home visits have continued as children and youth are referred by DCBS. Foster care support programs continue uninterrupted. OCSHCN has a full staff of nurse consultant inspectors, who have completed orientation and training and take referrals. The coverage area continues to be the entire state.

OCSHCN's Foster Care Support Section appreciates DCBS's continued support. Agency leadership continues to feel that the partnership with DCBS is a vital one, and remains consistent with OCSHCN's mission. As a Title V (Maternal and Child Health services) agency, OCSHCN prepared a five-year needs assessment in 2015, results of which guide the direction of services, especially with regard to any new or expanded programs. Priorities for the years 2016-2020 include transition to adulthood, improving access to care and services, ensuring adequate insurance coverage, and enhancing agency data capacity. In light of Kentucky selecting transitions services as a Title V National Performance Measure, emphasis will be placed on ensuring services for youth health care transitions to adult care in the child welfare area as well as with those youth enrolled in OCSHCN clinical programs and others served by the agency. In 2019 a new statewide 5-year needs assessment will be conducted and new priorities developed based on the results.

AA. Passport Health

The Passport Health Plan (Passport) is a provider-sponsored health maintenance organization (HMO) that provides medical services for children 0 to 18 years of age. Passport serves approximately 170,000 members in the Commonwealth of Kentucky, which is comprised of the following 16 counties: Jefferson, Oldham, Trimble, Carroll, Henry, Shelby, Spencer, Bullitt, Nelson, Washington, Marion, Larue, Hardin, Grayson, Meade, and Breckinridge. Passport is a Medicaid program. Children in foster care in the above counties are specifically supported by a liaison between Passport and the child welfare agency. Program staff ensure that children who come into care have medical coverage that promotes healthy development and better outcomes for all who are involved. A monthly report is developed to guarantee that children in care are presently active with Passport so that coverage is available to pay for all their medical claims. A certain code is entered into Passport's system for children in care to declare special privileges for extended coverage. In addition, daily information is specified regarding the status of a child's placement to ensure ongoing health coverage as well. On a monthly basis, service plan forms are given to Passport to review with a social worker to see which children need medical case management. Case management services can be for physical, mental, and/or behavioral health. When a child may need specialized services regarding a unique medical challenge, the MCO liaison coordinates services to meet individualized needs to ensure positive outcomes. Passport's social worker collaborates with child benefit workers to review the health needs associated with Passport. Passport social workers, central office MCO liaisons, and child benefit workers ensure that mental and physical health services are utilized appropriately in cost and care, and that there are comprehensive referrals being made when needed to ensure positive outcomes.

BB. Prevent Child Abuse Kentucky

The mission of Prevent Child Abuse Kentucky (PCAK) is to prevent the abuse and neglect of Kentucky's children. Goals include promoting public awareness regarding the prevalence of child abuse and neglect, increasing engagement in the prevention of child abuse and neglect, and developing effective

prevention strategies and programs. PCAK is a statewide, non-profit network of partners, professionals, and volunteers cooperating to develop and maintain child abuse prevention programs throughout the Commonwealth. Through the various community-based programs, parents and children are afforded the opportunity to learn and create a positive attitude toward their differing roles. With this knowledge, the cycle of child abuse can be broken; the aspects of abuse can be identified, treated, and prevented; and parents and children can develop and maintain open, warm, and loving relationships.

On January 1, 1987, PCAK was created through a merger of Parents Anonymous of Kentucky and the Kentucky Chapter for Prevention of Child Abuse. These two statewide agencies were formed in Kentucky in 1977-1978 and had been active as pioneers in the child abuse field since their creation. The merger resulted from a desire to combine the primary, secondary, and tertiary prevention aspects of the two autonomous agencies. This merger created the Kentucky Council on Child Abuse and the board of directors approved the name change to "Prevent Child Abuse Kentucky" in April 1999. PCAK is affiliated with Prevent Child Abuse America, headquartered in Chicago. The agency is statutorily funded utilizing a portion of state birth certificate fees (KRS 213.141).

PCAK works closely with CHFS personnel to ensure the goals and services provided under its programs are aligned closely with the overall Child and Family Services Plan. All subcontractors, which are local community agencies, are required to implement evidence-based parent education/support group services. All subcontractors are required to have a process to receive referrals from the state child welfare agency and serve families at risk. PCAK subcontracts, through annual requests for proposal, with programs serving parents in each of the nine service regions. The state office of PCAK provides the administration, coordination, training, maintenance, and enhancement functions necessary to allow the evolution of viable child abuse prevention options for families. PCAK conducts a variety of outreach programs (Kids Are Worth It! ® Child Abuse Prevention Conference; self-help, parent education, and support groups; educational workshops and institutes; 1-800 CHILDREN parent support resource; Partners in Prevention; Child Abuse Prevention Month; awareness tools, and fatherhood initiatives) throughout the year. Each activity is reported separately below.

Prevent Child Abuse Kentucky (PCAK), Kids Are Worth It! ® Statewide Child Abuse and Neglect Prevention Conference

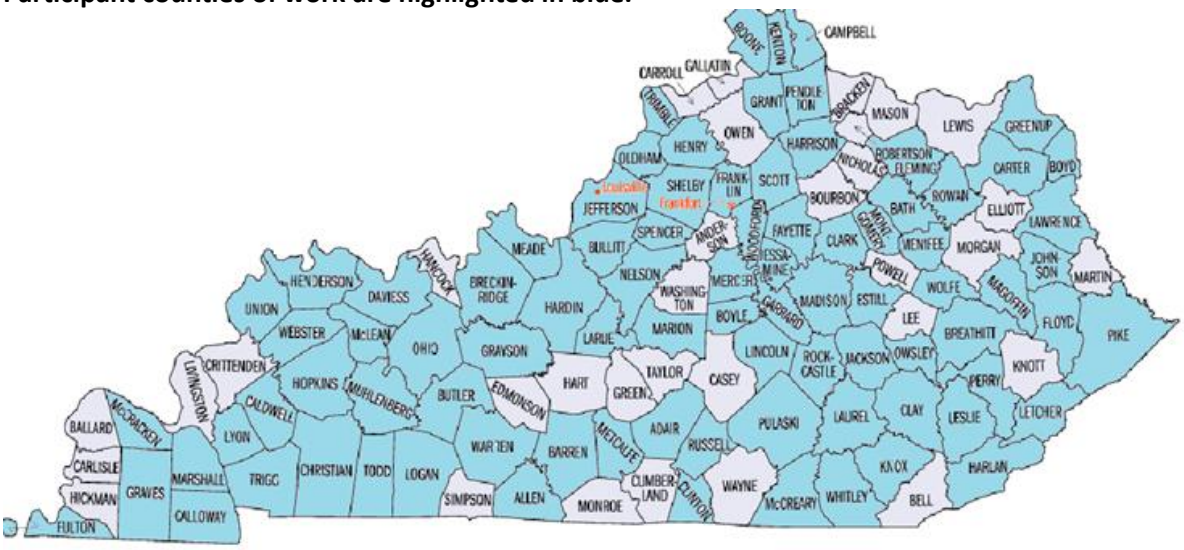
Kids Are Worth It! ® (KAWI) Conference is a statewide child abuse and neglect prevention conference. The conference focuses on child abuse and neglect issues across the prevention continuum from primary prevention through permanency planning for youth in care. The conference meets the training, continuing education, programmatic and networking needs of a broad, multidisciplinary audience. Workshop, plenary and networking sessions offered provide participants with information and tools to promote and support best practice. Participants learn new skills, receive information to enhance existing skills, and are provided networking opportunities to improve relationships and collaboration with colleagues working within or in support of the child welfare system.

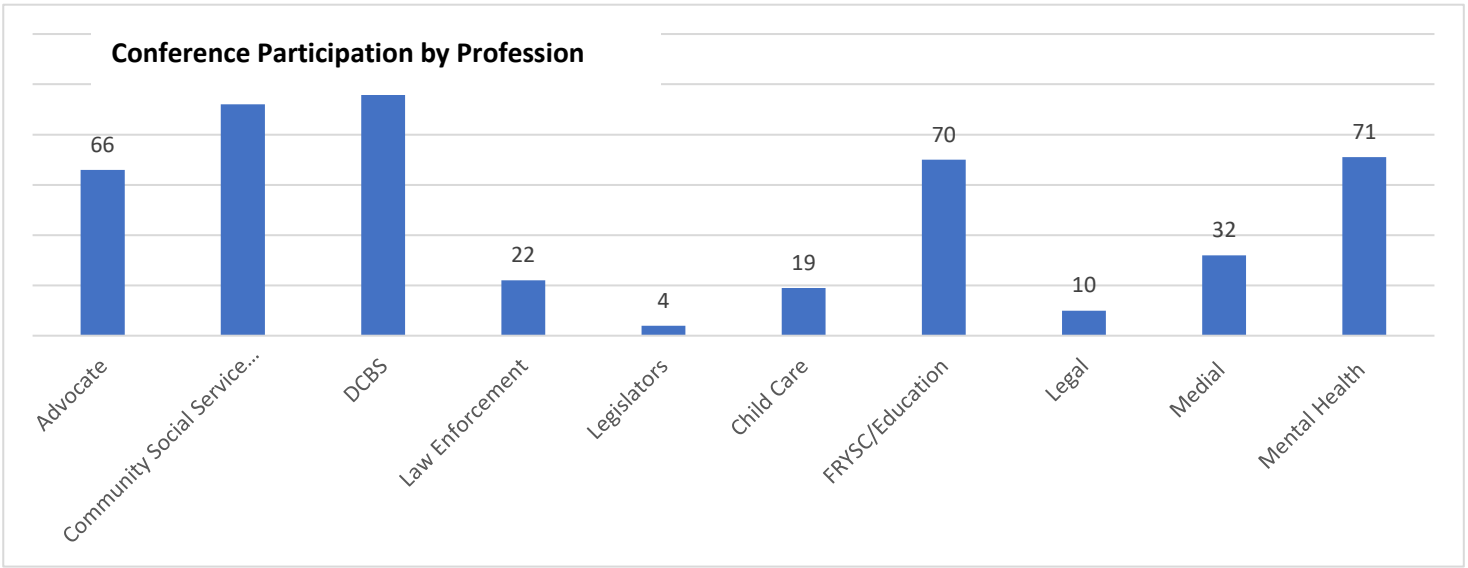
The conference is funded through CBCAP, grants, sponsorships and private/corporate donations. The conference is planned collaboratively between PCAK staff and a diverse advisory committee representing a variety of disciplines (including legal, public health, mental health, substance abuse, community services, medical, and law enforcement). This committee also represents varieties of geographical regions across the state. The Kids Are Worth It! ® Conference provides a unique training opportunity to both staff and service providers within the child welfare system. State and national experts provide high quality, state-of-the-art workshop and plenary sessions relevant to the broad audience providing a

variety of services to children and families. Care is taken to ensure all material presented are relevant to participants regardless of geographic location within the state.

The 2018 Kids Are Worth It! Conference was delivered September 17-18, 2018, at the Crowne Plaza in Louisville. The conference reached 639 individuals with 532 participants attending workshop and plenary sessions. In addition to the provision of thirty-eight workshops, there were two keynote sessions. Participants from 88 counties (identified in the Kentucky map below), across all nine DCBS Service Regions were present; representing 73% of Kentucky counties.

2018 Participant Representation Map
Participant counties of work are highlighted in blue.





An *Overall Conference Evaluation* was provided to attendees at the conference. Two-hundred and ninety-four *Overall Conference Evaluations* were received. Participants rated their overall experience on

a five-point Likert scale. The overall conference evaluation responses, provided below, reflect a high-quality experience for participants.

This percentage represents those who indicated they were either Extremely Satisfied or Satisfied with the category below:

Please rate your overall experience:	**2018 Overall Responses**
a. Conference as a whole	98.64%
b. Registration process	97.96%
c. Workshop choices	95.92%
d. Keynote sessions	97.28%
e. Networking opportunities	90.81%

This percentage represents those who indicated they Strongly Agreed or Agreed with the category below:

As a result of attending the conference:	**2018 Overall Responses**
a. I am better prepared to prevent child abuse and neglect.	96.26%
b. I learned of a new resource, which will assist me in my work to improve outcomes for children and families.	95.91%
c. I learned a new skill, which will assist me in my work to improve outcomes for children and families.	95.56%
d. I was able to network with community partners.	91.47%

Open-ended responses were solicited on the overall evaluation in addition to individual workshop evaluations. When asked what aspects of the conference you found most beneficial, respondents indicated the following:

- *"Another job well done! I feel re-energized and motivated to make a difference. Participants were made to feel appreciated too. Well organized!"*
- *"The workshops helped me not only on a professional level but also a personal level as I have a 14 and 15-year-old. Loved it!"*
- *"Great speakers! Enjoyed the different options of classes to take. Loved exhibit hall-variety of vendors was great."*
- *"So many great topics, not enough time to listen to them all. Situational Awareness, Human Trafficking and the Electronically Addicted Brain were amazing, as well as Corporal Punishment."*
- *"The keynote speaker, Mr. Mulcahy was quite possibly the best speaker I have ever heard. It was beneficial to hear what we can do in those experiences."*
- *"BEST Conference EVER! Been to many and this one far exceeds all the others."*

As a tool to assess extended impact of knowledge gained through the conference, participants were emailed an invitation to participate in a 60-day follow up survey. One hundred and fifty-six participants responded, yielding a 31% response rate. Participants continue to report the conference experience as impactful. A summary of results follows:

- 82% agree or strongly agree they learned a new skill by attending the conference.
- 93% agree or strongly agree the different perspectives provided in multi-disciplinary workshops and keynotes positively affected their work.
- 76% agree or strongly agree they utilized a new resource to support families.
- 71.87% agree or strongly agree they are better prepared to prevent maltreatment as a result of attending the Kids Are Worth It! Conference. 28.16% report remaining neutral.

Respondents who indicated the education they received through the conference changed their practice were asked to describe how their work has changed. A sampling of comments includes the following:

- *"Better awareness of families with domestic violence and drug issues. Excellent keynote speaker gave great understanding of how a child might hide sexual abuse."*
- *"I have been able to share use the information I learned to create a better class and pass along better information to parents. I have been able to use the information I learned to help those I serve to become better advocates for themselves as well as being a better advocate for them when I can."*
- *"I felt validated and inspired by the speakers and colleagues at the conference."*
- *"One of the workshops I attended was information regarded upcoming DCBS changes. It helps to know what is coming up. The secondary trauma workshop as well as it serves as a reminder to be mindful of checking in on myself of how work impacts me away from work."*

Self Help, Parent Education, and Support Groups

Services are available in every service region and served 81 counties (of 120) in the state in 2018. Subcontractors are required to utilize the evidenced based Nurturing Parenting curricula along with administration of the parallel Adult-Adolescent Parenting Inventory (AAPI) pre- and posttest. The utilization of a single curriculum enhances programmatic consistency across service providers and strengthens program evaluation through universal use of the AAPI. PCAK created a single account with provider satellites for providers to enter their AAPI data, which allowed for collection and data analysis. Currently, one PCAK staff members are trained facilitators of Nurturing Parenting and Parent Café as a way to enhance self-help work. Programmatic, training and evaluation changes have been implemented to encourage integration of the protective factors framework into service delivery. Furthermore, providers are required to administer a drug and alcohol screening tool to all participants at intake. Majority of the providers use UNCOPE. As part of service delivery, each provider offers an education component on child welfare, from investigation to case resolution. Subcontractors are asked to distribute the child welfare agency's child removal handbook, "When Your Child is Removed from Your Care" and parents are asked to complete the child welfare agency's Customer Satisfaction Survey. This year DCBS Executive Advisor, Jennifer Warren, attended the provider meeting to discuss continued collaborative improvements between providers and the child welfare agency.

The content delivered each week of the parent education sessions and/or support group is designed to provide parents with skills relevant to healthy parenting, while encouraging permanency and well-being within the family structure. PCAK collects attendance and referral data from each subcontractor monthly during each state fiscal year. An analysis of the calendar year records reflects 1,410 families began a parent education and/or parent support program with one of the 16 providers during 2018. In this period, PCAK subcontractors provided 15,183 duplicated incidents of service.

PCAK staff utilizes a two-prong approach to measure program impact. For several years, the program has been evaluated through a retrospective survey collected from participants at program completion.

Questions on the survey instrument focus on demographic data, as well as parenting skills gained while attending the program and how the individual feels about him/herself afterwards. Program participants are clearly told their answers will not have any impact on an individual's personal situation. This self-report tool has consistently shown positive program impact.

In 2018, PCAK conducted an in-depth analysis of the AAPI pre- and post-test data collected from parent education program participants. The Adult-Adolescent Parenting Inventory (AAPI) is a tool used to measure the effectiveness of PCAK's parent education programs. Based on the known parenting and child rearing behaviors of abusive parents, responses to the inventory provide an index of risk for behaviors known to be attributable to child abuse and neglect. The AAPI is universally recognized as a valid and reliable tool used to assess parenting attitudes, knowledge, and history.

The AAPI includes both a pre- and post-assessment. The pre-test collects data to determine the program participant's entry-level capabilities. The post-test data is collected at the completion of the program to determine level of growth and future intervention needs of the family.
The information gained through this assessment includes:

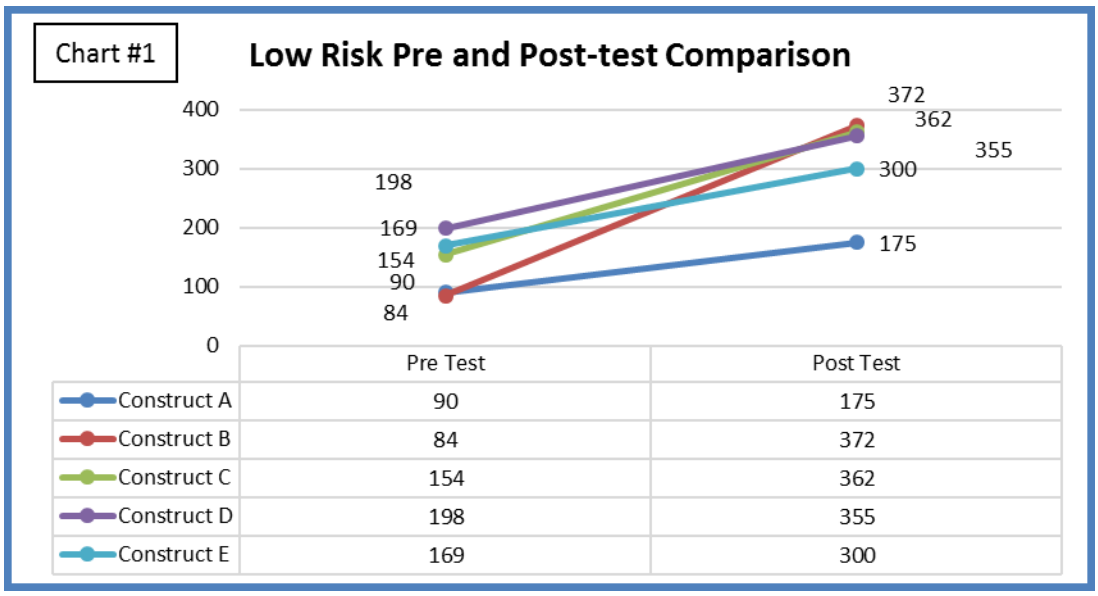
- Knowledge: What do parents know about appropriate parenting practices?
- Attitudes: What attitudes do parents have about raising children?
- History: What childhood history do parents and teens have that affects their parenting?

Responses to the AAPI provide an index of risk in five specific parenting and child rearing behaviors:

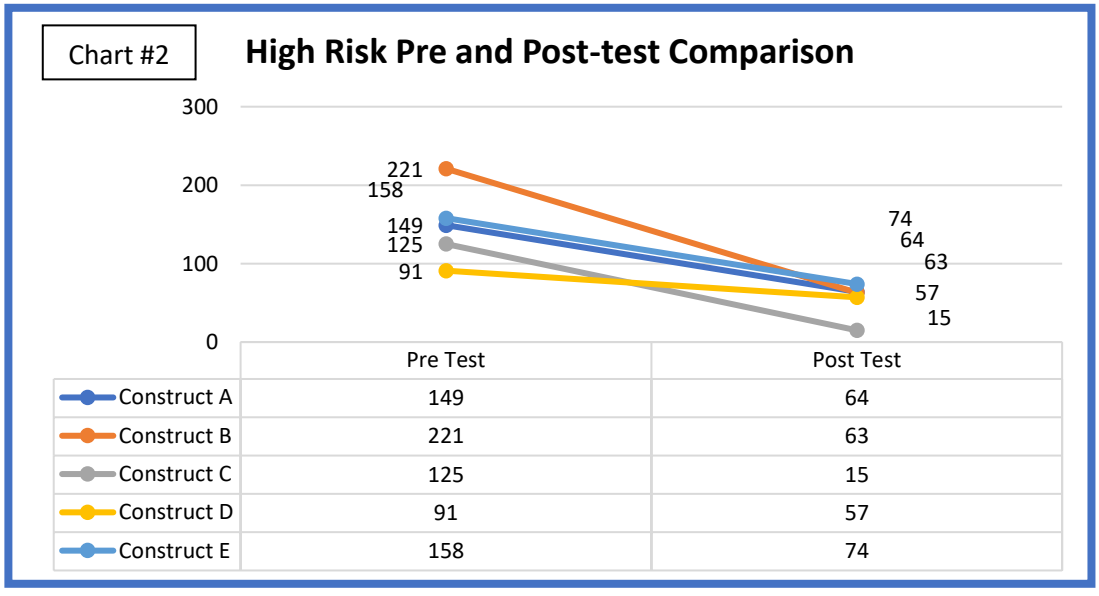
- Construct A - Inappropriate Expectations of Children
- Construct B - Parental Lack of Empathy Towards Children's Needs
- Construct C - Strong Parental Belief in the Use of Corporal Punishment
- Construct D - Reversing Parent-Child Family Roles
- Construct E - Oppressing Children's Power and Independence

Parents who score "high risk" in the constructs measured by the AAPI are at greater likelihood of abusing their children.

In summary, participants in PCAK's parent education program demonstrated significant positive changes in all five constructs measured by the AAPI. The number of families found to be at low risk increased while the number of families at high risk decreased. Chart #1 reflects an increase in the number of families at low risk, and Chart # 2 demonstrates similar movement in families from high risk toward low risk behaviors and attitudes.



LOW RISK Pre and Post-test Comparison (Chart #1): The pretest results demonstrate the number of parent education participants within the low risk category for each construct at the beginning of parent education classes. The post-test results demonstrate the number of parents moving from high or medium risk category to the low risk category at the end of their parent education classes.



HIGH RISK Pre and Post-test Comparison (Chart #2): The pretest results demonstrate the number of parent education participants within the high-risk category for each construct at the beginning parent education classes. The post-test results demonstrate the number of parents remaining in the high-risk category at the end of their parent education classes.

Rates of movement within each construct are summarized below:

Construct A *addresses appropriate and inappropriate expectations of children*.

Explanation: Parents who exhibit low risk in this category understand growth and child development and tend to be supportive of their children.

Findings: An indication of the positive impact of the PCAK parenting education programs include a **94.44%** *increase* in the number of parents at *low risk* for Construct A. In direct correlation, the number of parents high risk in Construct A saw a *reduction* of **57.05%**.

Construct B *assesses the ability of parents to demonstrate empathy towards their children*.

Explanation: Parents exhibiting a high level of empathy understand and value their children's needs. Children are nurtured and encouraged to display normal developmental behaviors. Parents increase their capacity to recognize the feelings of their children and are more successful at communicating with them in a healthy manner.

Findings: In Construct B, results included a **342.86%** *increase* in the number of parents considered to be at *low risk* to abuse their children while the percentage of parents considered to be at *high risk* in this category was reduced by **71.49%.**

Construct C *addresses parental belief in the use of corporal punishment*.

Explanation: Parents who are considered low risk demonstrate an understanding of alternatives to physical force while disciplining their children; these parents tend to have respect for their children and their needs.

Findings: The number of parents considered to be at *low risk increased* by **135.06%** while the number of parents considered high *risk* in this category was *reduced* by **88.00%.**

Construct D *focuses on parental ability to enforce appropriate parent-child family roles*.

Explanation: These parents tend to have adult relationships where their needs are met. They find comfort, support, and companionship from peers, thereby allowing and encouraging their children to grow and develop at their own pace. Parents who exhibit high-risk behaviors tend to perceive their children as objects for adult gratification and treat their children as confidants and peers.

Findings: Following completion of the parenting education program, there was a **79.29%** *increase* in the number of parents considered to be at *low risk* while there was a **37.36%** decrease in the number of parents considered to be at *high risk*.

Construct E *addresses parental capacity to support the child's power and independence*.

Explanation: The parent who is considered to be at low risk places a high value on children's ability to problem solve and make good choices. Children are encouraged to express their own views while remaining cooperative and respectful of their parents.

Findings: There was a **77.51%** *increase* in the number of parents considered to be at *low risk* for abusing or neglecting their children and a **53.16%** decrease in the number of parents considered to be at *high risk*.

Prevent Child Abuse Kentucky (PCAK), Educational Workshops and Institutes

Prevent Child Abuse Kentucky (PCAK) provides educational offerings to requesting groups statewide, focusing on issues impacting local communities and actively engaging the community in preventing child maltreatment. Activities are supported through CBCAP funds, PCAK general funds, grants, private donations, training honoraria and corporate giving. PCAK offers specialized trainings, train-the-trainer workshops, and continuing education credit for participants. Curricula on a variety of child maltreatment related topics are available and each audience participates in an individualized learning experience. PCAK has expanded it training offerings, now providing the following workshop topics:

Adverse Childhood Experiences: Understanding and Responding to Toxic Stress

Fifty-nine percent of Kentuckians report experiencing at least one adverse childhood experience, such as child maltreatment. These traumatic events can have a negative impact on the health and social wellbeing throughout someone's lifespan. In a safe, stable, and nurturing environment, children can adapt and build resilience in response to these negative experiences. This workshop explores current research regarding the impact of toxic stress, evidence informed practices designed to mitigate the effects of toxic stress on children and strategies for supporting families.

Child Fatality Review Teams in Kentucky

The Child Fatality Review System is the state's response to childhood deaths: a system designed to learn what we can and develop strategies to prevent childhood deaths. Attendees of this training will be able to: (1) Identify the composition of the Local Child Fatality Review Team; (2) Identify the function of the Child Fatality Review Team; (3) Identify the goals of the Local Team; (4) List best practice models for child death investigation and case review; and (5) Identify opportunities to integrate case review findings into local prevention efforts.

Engaged Fathers: Improving Outcomes for Children

Fathers are instrumental in the healthy growth and development of children. This workshop reviews research on the positive and negative outcomes, which are directly influenced by the involvement of fathers in children's lives. Attendees are provided with tools to assess the "father-friendliness" of their organizations and service delivery models. Discussion surrounds changes in practice which, when instituted, may affect the engagement of fathers in the lives of children.

Internet Safety

The Internet Safety training provides strategies to EDUCATE, MONITOR, and COMMUNICATE internet safety. Because of this training, participants will understand risks and learn how to keep children protected both from unsafe material as well as from predators who are unyielding in their efforts. This training has been designed to support parents and other caregivers in their efforts to assure the safety of children in their care.

Kentucky Strengthening Families

Supporting families is a key strategy for promoting school readiness and preventing child abuse and neglect. Attendees will learn how to apply the KYSF Protective Factor Framework in their community, organization, or program through the following training objectives: (1) Ability to list and explain each of the six Protective Factors; (2) Recognizing the importance of strengthening families based on research; (3) Identifying strategies for how your program can align current program practices with the Protective Factors; and 4) Developing a plan for how you will promote the protective factors in your workplace so every interaction you have with families is strength-based and high impact.

Kentucky Strengthening Families Training of Trainers
KYSF represents a multi-disciplinary partnership of over 20 national, state and local, and public and private organizations dedicated to embedding six research-based Protective Factors into services and supports for children and their families. Supporting families is a key strategy for preventing child abuse and promoting school readiness.

Prevent Child Abuse Kentucky is excited to be able to deliver the KYSF Training of Trainers curricula to those interested in delivering this training in their communities. This curriculum enables trainers to provide the three-hour training for interested community members. They will be able to share the importance of Strengthening Families based on the research behind the movement. Trainers will also be able to help participants develop a plan for how they will promote the six Protective Factors in the workplace so every interaction with families will be strength-based and high-impact. Participants receive an individual set of training materials including the PowerPoint presentation, access to videos, evaluation documents as well as other materials.

Pediatric Abusive Head Trauma
Kentucky statute requires education on the identification and prevention of Pediatric Abusive Head Trauma. In partnership with experts in child maltreatment, PCAK has developed curricula to meet the needs of a variety of professionals impacted by this legislation.

Preventing Child Maltreatment Death: A Community Effort
Everyone has a role to play in keeping children safe and ensuring children reach their full potential. Through lecture and group work, participants are empowered to act to end the tragedy of child death and near death at the hands of those charged with caring for them.

Protecting Your Children: Advice from Child Molesters
Using film clips of interviews with various types of sex offenders, participants will understand the techniques perpetrators use to target, seduce, and exploit children. This workshop will challenge common misperceptions about children's ability to protect themselves and promote the idea that all adults must be informed and take an active role in promoting child safety. Participants will learn effective prevention strategies for use in a variety of settings.

Protocol for Youth-Serving Organizations, Colleges & Universities: How Do You Keep Children and Youth Safe While Under Your Supervision?
Summer camps, colleges/universities, athletic organizations, the faith community, and other youth-serving organizations all have a duty to ensure the children and youth they serve are safe while under their care. This training is suitable for athletic personnel, Title IX administrators, summer camp counselors/staff, and others. The training covers topics including recognizing & reporting child abuse, strategies for screening and selecting employees and volunteers, strategies for ensuring safe environments and others. A planning tool for organizations is included in the training.

Recognizing, Reporting, and Preventing Child Abuse and Neglect
Through lecture, video, injury identification, and group work, attendees are prepared to recognize, report, and prevent child abuse and neglect within their role as child and/or family-serving professionals. This workshop reviews Kentucky mandated reporting laws, definitions of abuse and neglect, what to expect after a report has been made to the authorities and outlines specific action steps which prevent child maltreatment.

Stewards of Children
PCAK staff is credentialed by the Darkness to Light organization as an Authorized Facilitator of the Stewards of Children curriculum. Stewards of Children is an evidence-based workshop, documented to "increase knowledge, improve attitudes, and change child-protective behaviors." The 2-3-hour workshop is conducted in small group settings and is geared toward all adults interested in preventing child sexual abuse.

The Connection between Intimate Partner Violence and Child Maltreatment
Intimate Partner Violence (IPV) affects the entire family and is found in approximately 55% of KY households with substantiated cases of child maltreatment. Attendees will learn about common dynamics of IPV, how children are impacted by the violence and techniques for preventing child maltreatment when working with families impacted by IPV.

Understanding Typical Child Development: A Tool to Prevent Child Sexual Abuse
Understanding typical child sexual development is critical to keeping children safe. Often parents do not understand when and how to discuss sexual abuse. Training participants will understand the typical stages of child development and learn how to help caregivers talk to their children about healthy sexual development as a tool to prevent child sexual abuse.

Working with Families in Substance Abuse Recovery
Substance abuse is commonly present in cases where child maltreatment has been substantiated. Through lecture and group work, attendees will become familiar with the continuum of prevention, the connection between substance abuse and child maltreatment, and specific techniques to prevent child maltreatment in families impacted by substance abuse.

PCAK will continue to provide educational workshops and institutes to the public as requested. Additional PCAK staff are being trained as workshop presenters. As new workshops are developed at the request of participants, PCAK's listing of workshop topics continues to increase, and is always shared on our website: https://www.pcaky.org/trainings. As communities become more aware of PCAK workshops and educational offerings as a resource for preventing child maltreatment, PCAK receives greater numbers of requests.

PCAK collaborates with DCBS and other key stakeholders to ensure workshops and institutes serve as high quality professional development venues, applicable to the needs of diverse audiences. PCAK workshops and institutes are strategically located to ensure child maltreatment prevention education is accessible to audiences statewide. PCAK promotes trainings through networking and engagement of community partners. Invitation listings are developed based on the target audience and region of the state in which it will be located. Partners instrumental in announcing events include DCBS; the Department for Public Health, DBHDID; DCC; FRYSCs; and well as other locally based entities. PCAK utilizes web-based advertising including the website, electronic newsletters, and social media (Facebook, Twitter).

Workshops and institutes, which are specific to one discipline, include a segment on the importance of a multi-disciplinary approach to prevention. PCAK provides workshops and institutes, which incorporate components across the entire continuum of prevention. Participants are equipped with knowledge on risk factors, warning signs, and protective factors, which enhance the strength-based approach to prevention. Participants leave with tangible tools for working with children and families such as local and statewide community resources. Participants receive materials in addition to education. Training of

the trainer institutes provides training materials, resources for future participants, and ongoing technical assistance. DCBS staff members are invited to attend or participate as co-presenters in many PCAK trainings. This provides professional development opportunities for DCBS staff and encourages communities to align themselves with DCBS as a resource to assist in meeting local needs.

All PCAK educational workshops and institutes focus on protecting children from abuse and neglect and supporting families so children reach their full potential. Professionals are empowered to act when recognizing indicators of child maltreatment and to incorporate practices to enhance community and family protective factors. As an active member on the Kentucky External Child Fatality and Near Fatality Review Panel, PCAK utilizes experienced staff to provide accurate data on trauma, risk factors, and the protective factors that can prevent fatalities and near fatalities. Workshops on preventing pediatric abusive head trauma and the communities' role in preventing child maltreatment deaths broaden participants' understanding of the issue. Participants learn about PCAK resources and services including the annual Kids Are Worth It! ® conference; written and electronic materials; parent support programming; additional training opportunities; and, technical assistance for agencies wishing to incorporate child abuse prevention into their programs. PCAK utilizes resources, materials, and technical assistance from the national affiliate Prevent Child Abuse America. This relationship provides access to best practices from sister chapters throughout the country. Additionally, PCAK has utilized resources and information from Child Welfare Information Gateway, the National Center for Child Death Review, and many others.

During 2018, trainings were offered locally, regionally and statewide. PCAK provided training opportunities in each of the nine DCBS regions. Trainings often have a wide reach through statewide curriculum offerings and intentional offering of workshops in locations, which draw participants from surrounding counties. In 2018, PCAK served 1,304 participants, and provided 39 trainings. PCAK staff continues to be active on the KYSF Leadership Team and can integrate these concepts into other PCAK training curricula.

Prevent Child Abuse Kentucky (PCAK), 1-800-CHILDREN Parent Support Resource

The 1-800-CHILDREN parent support resource functions as a free parent support and referral service, which is available via phone, email, and the PCAK website. Funded by CBCAP, the 1-800-CHILDREN parent support resource line provides support to families to prevent incidents of abuse or neglect. Parents, caregivers, and the professionals offer support, encouragement, and information regarding local resources, which promote the safety and well-being of Kentucky children and families. The 1-800-CHILDREN parent support resource offers 24-hour access via email and the web. PCAK Staff answer calls 8:00a.m.-5:00p.m. Monday-Friday; during all other times, callers are referred to 1-800-4ACHILD to ensure 24-hour access to support via phone.

Staff are trained to respond to caller concerns and have access to a wide variety of resources. When parents, caregivers, and professionals contact the 1-800-CHILDREN parent support resource, callers receive guidance in problem solving and referrals to the most appropriate resources in their local communities. Utilizing local social service providers for referrals not only connects callers with local and accessible resources, but also builds the community's capacity to care for Kentucky children and families. The 1-800-CHILDREN parent support resource also serves as an engagement tool to connect citizens interested in learning about being involved in child abuse and neglect prevention efforts. Volunteer opportunities, specific child abuse and neglect related resources, and other pertinent information is provided.

The 1-800-CHILDREN parent support resource interconnects PCAK programs and services with family service providers statewide. The 1-800-CHILDREN phone line is advertised at all PCAK trainings and is included on all PCAK resource materials. Professionals working with children and families can provide this information to the clients they serve. The 1-800-CHILDREN parent support resource serves as the point of contact for citizens to learn about programs, information, events, and volunteer opportunities, which affect child maltreatment prevention. DCBS social workers are encouraged to share the 1-800-CHILDREN parent support resource with parents and caretakers involved with the DCBS system and can be utilized as a component of safety and aftercare planning when appropriate.

- Approximately 60,514 pieces of material displaying 1-800-CHILDREN were distributed throughout the Commonwealth during 2018.
- Staff communicated information regarding 1-800-CHILDREN during 39 formal trainings and numerous presentations on various topics to a variety of audiences reaching 1,943 individuals.
- Staff were involved in 53 outreach opportunities reaching 3,129 individuals statewide.
- The 1-800-CHILDREN parent support resource continued to include toll-free and local calling, email services, and web-based resource materials.

Data regarding usage of the 1-800-CHILDREN parent support resource is tracked monthly. Information captured includes number of calls received, the originating location for the call, type, and number of referrals made. Some notable data from January 1, 2018 to December 31, 2018 includes:

- 275 calls were made to the 1-800-CHILDREN toll free parent support line.
- On average, the 1-800-CHILDREN toll free parent support line was utilized 23 times per month.
- On average, 66.75% of all callers were referred to DCBS.

Since the last reporting period, 1-800-CHILDREN parent support calls to the toll-free number have remained stable. This could indicate individuals utilizing the services are able to have their needs met through local, alternative means, including email, calls to the local resources, and the web-based service directory.

PCAK places high value on the continuous quality improvement process and will continue analyzing 1-800-CHILDREN parent support resource data to ensure parents have access to high quality support via phone, email, and the web.

PCAK, Partners in Prevention

PCAK Partners in Prevention is a network of agencies, individuals, and businesses with coverage to the entire state. During 2018, PCAK had 235 Partners in Prevention. These partners allowed for statewide coverage. The network consists of service providers such as volunteer groups, schools, hospitals, businesses, mental health providers, faith-based entities and other community organizations working to spread the message of child abuse prevention. Affiliates are involved in PCAK programming such as trainings and workshops, Self-Help, Parent Education and Support Groups, Child Abuse Prevention Month (CAPM), Kids Are Worth It! Conference, as well as regional and community awareness campaigns. PCAK takes a targeted approach in contacting, meeting with, and formalizing partnerships with groups who will utilize the resources provided in a method increasing the development of awareness and prevention work across Kentucky.

All partners are involved in work to bring awareness to child abuse and neglect by distributing and sharing PCAK prevention information throughout their region. Qualitatively, PCAK maintains relationships with each individual partner, offering technical assistance to help build greater capacity in meeting prevention program and awareness needs of partners. Conversation and observation find

partners are pleased with their experience through this network. Partners continue to assist PCAK in becoming a clearinghouse for Child Abuse Prevention Month ideas, seeking funding opportunities for prevention efforts that are well dispersed across the state, and continually brainstorming ideas and applying strategies to engage communities in each region.

As a part of the agency's quality improvement efforts, PCAK staff initiated a plan to examine our existing partnership efforts. PCAK staff assembled a workgroup who examined existing practices on an ongoing basis. This group's strategic plan included increased partner engagement via regional partner meetings, quarterly updates via electronic newsletters and emails, and allowing partner conversations from these initiatives to drive next steps in developing appropriate prevention resources for the state. Meetings were held in five locations during 2018, including Somerset, Lexington, Murray, Florence, and Bowling Green.

Using input from these meetings, staff continue to review all resources, materials, trainings, and website content. Partner meetings have further led staff to a plan for reviewing the reading level and content of all current brochures; review options for addressing non-English speaking resources; investigate digital mobile capabilities; develop a plan for creating more Public Service Announcements; and use meeting outcomes to drive content for partner newsletters. This process has been ongoing during 2018, and 2019 will be further opportunities to expand our work with partners across the Commonwealth.

Prevent Child Abuse Kentucky (PCAK), Child Abuse Prevention Month (CAPM)

During national child abuse prevention month, PCAK provides leadership to a statewide public education and awareness campaign to promote child abuse and neglect prevention. Efforts are funded through CBCAP, corporate and individual donations. PCAK collaborates with the state child welfare agency, community partners, professionals, parents, and caregivers to develop resources and materials. Awareness materials provide individuals with statewide information and services; and are made available through the PCAK website, trainings and community meetings. The 2018 child abuse prevention month campaign included the following activities:

- Via Gubernatorial Proclamation, April 2018 was declared Child Abuse Prevention month. Many communities across the state hosted proclamation ceremonies, engaging local elected officials such as mayors and judges, declaring April Child Abuse Prevention Month. PCAK distributed local proclamation templates as a strategy to ensure consistent messaging throughout the state.
- On March 22, in conjunction with the Office of the Governor and First Lady Bevin, PCAK held a statewide kickoff to include a pinwheel planting on the Capitol Lawn. Many partners showed up to plant pinwheels to bring awareness to child abuse and neglect in Kentucky. Following, PCAK hosted a networking reception where Governor Bevin signed a proclamation.
- Communities across the state held an array of events to include community proclamation ceremonies, pinwheel plantings, rallies, family-fun activities, trainings/conferences, and resource fairs.
- PCAK leadership continued a partnership with the Kentucky Press Association (KPA) to facilitate engagement of statewide media outlets. The KPA sent a media advisory to all members regarding CAPM and encouraged local media outlets to provide coverage.
- There were 271 CAPM related events reported to PCAK in 2018.
- Staff developed CAPM resources available through the PCAK Information and Data Center. Resources included campaign ideas, templates for media outreach, event planning, faith-based materials, statistics and relevant data, tip sheets for parents and caregivers, and suggestions for engaging communities in grass roots prevention efforts.

- Staff developed a tool kit with instruction and resources on both implementing Child Abuse Prevention Month efforts as well as the Pinwheels for Prevention Campaign. This resource was used to assist local groups in the planning and hosting of awareness activities.
- Over 36,163 pinwheels were distributed across the Commonwealth.
- There were 5,475 pinwheel lapel pins distributed across the Commonwealth.
- There were 214 yard signs distributed across the Commonwealth.
- Electronic announcements promoting child abuse prevention month and the availability of the online resources were distributed via social media, the PCAK webpage and email distribution. There were 37,166 hits to the PCAK webpage during the campaign.
- Targeted announcements were also sent to DCBS staff, educators, mental health professionals, childcare providers, law enforcement officials, health departments, and legal professionals.
- 100% of Kentucky counties were engaged with PCAK in child abuse prevention month efforts.
- In advance of and during the month, 40,900 child abuse awareness materials were distributed across the state to local communities.
- During the 2018 campaign, there was an increase of 497 Facebook likes, and 112 Twitter followers.

Resources made available by the Children's Bureau were utilized in the development of the 2018 CAPM materials. Links to the Children's Bureau and other national organizations were provided on the PCAK website as resources to local communities. PCAK also benefits from affiliation with Prevent Child Abuse America and sister chapters throughout the country. This affiliation provides ideas and resources to strengthen Kentucky's efforts.

Prevent Child Abuse Kentucky (PCAK), Awareness Tools

Using CBCAP funds, corporate and in-kind donations, PCAK provides an array of awareness tools throughout the year. Based on the varying learning styles of adults today, and the ways people receive information, awareness tools include brochures, electronic resources, as well as video**,** print and media campaigns. We have coined this group of resources as the "PCAK Information and Data Center," a term reflecting the variety of media through which tools are distributed. Awareness tools serve to strengthen the ability of the public and professionals of the Commonwealth to gain knowledge regarding the issue of child abuse and neglect. CHFS staff and community partners are consulted regarding emerging trends in the field of child abuse and neglect prevention. This information assists in determining the content and topics of awareness materials offered by PCAK. These community partners, in conjunction with PCAK staff, provide ongoing review of materials to ensure the accuracy of the information available for distribution. Examples of awareness tools available on these subjects include:

- "Ages and Stages: A Parent's Guide to Discipline" brochure designed to educate individuals on child development and keys to effective discipline.
- "Hold Them, Hug Them, Love Them But Never Shake a Baby" brochure designed to educate parents on the dangers of shaking a baby, and provider tips for coping with crying.
- "How Well Do You Know Your Love Interest" brochure is a guide for caregivers in choosing a partner, focusing on the impact this decision has on a child.
- The Internet Safety Toolkit is an easy to comprehend guide for parents and caregivers to provide education on internet safety.
- "Preventing Child Neglect" brochure defines neglect and educates the reader on how to recognize and respond to neglect.
- "Preventing Child Sexual Abuse" brochure educates readers on the dynamics of child sexual abuse and prevention strategies.

- "How do I Choose a Safe Caregiver" Tip Sheet educates readers on the importance of choosing someone safe to care for their child.
- "Understanding Typical Healthy Child Development" Tip Sheet educates readers on what to expect from their child as he/she develops.
- "As a Parent, What Can I do to reduce the Risk of Child Sexual Abuse" Tip Sheet educates parents on ways to reduce the risk of sexual abuse for their children.
- "Coping with Crying" Tip Sheet educates parents on ways to deal with baby's crying, in effort to reduce stress and acting out in harmful ways, reducing pediatric abusive head trauma.
- "Summer Camp Tips – Selecting the Right Camp" educates parents on the questions to ask prior to enrolling their child in any summer camp or youth serving organization activity.
- "When a Child Talks About Sexual Abuse…" Tip Sheet addresses how adults should react and respond to child sexual abuse disclosures.
- "Recognizing Child Sexual Abuse – Know the Facts" Tip Sheet educates adults on the statistics, definition, safety tips, and warning signs around child sexual abuse.
- "Child Sexual Abuse Risk Reduction Protocol for Youth-Serving Organizations" is a guide designed for youth-serving organizations who are interested in adopting strategies to prevent child sexual abuse.

All resources are driven by needs identified within Kentucky and designed to meet the needs of parents and professionals. For instance, because pediatric abusive head trauma is the primary cause of physical abuse deaths in Kentucky, tools and awareness campaigns addressing this have been deemed critical. In addition, research has shown the reality that many children each year are abused by their parent's love interest or their caregiver, which deemed it necessary to have a resource to help parents make these decisions.

PCAK has worked to ensure the online resources are available on our website, www.pcaky.org, to include electronic copies of all available brochures, parenting tip-sheets, and tools for involvement in awareness campaigns such as Pinwheels for Prevention or Child Abuse Prevention Month. The online Information and Data Center continues to be used widely throughout the state for ordering and downloading child abuse prevention resources: https://www.pcaky.org/information-and-data

Through a grant from CVTF, PCAK developed and launched a child sexual abuse prevention campaign during April 2018, using media messages airing on television, radio and appearing in print. Video-based awareness tools were also created. All resources are available on PCAK's website, YouTube channel, and Facebook page.

YouTube: https://www.youtube.com/user/PCAKY
Website: https://www.pcaky.org/node/254
https://www.pcaky.org/webinars-educational-videos

Further, PCAK has increased efforts for the "Ask the Expert" campaign in 2018, releasing videos on topics such as child abuse and neglect data and research, Child Abuse Prevention Month, grandparents raising grandchildren, father engagement, and OOHC. These Ask the Expert videos had approximately 2,997 total views. Staff will continue to work to enhance this awareness and educational initiative into 2019.

The agency will continue to work with CHFS, community partners, and when appropriate, national organizations, to stay abreast of current variables in the field of child abuse and neglect prevention in an on-going effort to maintain and expand our resources. Trends continuing to emerge in 2018 include internet safety, child sexual abuse prevention and the way we talk about it to the public, evidence-based prevention, pediatric abusive head trauma, prevention/awareness programs targeted to children, parenting strategies, grandparents raising grandchildren, trauma-informed care, building child and parent resiliency, child fatality prevention and strengthening families through building protective factors. PCAK works collaboratively with community partners to promote systems improvements by creating tools to support multi-tiered prevention of abusive head trauma for parents provided by birth hospitals, healthcare professionals, and home-visiting programs. Staff have also collaborated with medical professionals, childcare providers, parenting programs, early child home visiting programs and other agencies towards developing a statewide public awareness campaign to address "safe sleep." Staff continued conversations with the KY Hospital Association, while receiving a grant from WellCare Health Plans of KY, to update prevention resources around pediatric abusive head trauma prevention. These new resources are scheduled to roll out spring of 2019.

Citizens and professionals are encouraged to utilize PCAK's awareness tools to educate and advance their knowledge as to the existence and impact of child abuse and neglect. The utilization of social media has proven to be advantageous for the agency, allowing PCAK to reach a multitude of citizens who may not have traditionally been familiar with the agency.

PCAK tracks baseline data regarding awareness tools requested and distributed.
Included in this tracking system are the parties requesting materials, number of materials requested, and distribution location. PCAK believes awareness promotes education, which, in turn, plays a relevant role in the reduction of incidences of child abuse and neglect. In 218, over 67,606 pieces of materials, with 1,853 downloads (PCAK is unable to track duplications) were distributed across the Commonwealth designed to educate and promote awareness of child abuse and neglect. PCAK encourages the reproduction of this literature, many agencies make copies of the brochures and pamphlets sent to them by PCAK and distribute them to other local agencies and civic organizations. To assist in meeting this need, PCAK has developed printer friendly online versions of printed material. During 2018, 4,396 followers liked agency's Facebook business page. Twitter followers grew to 3,147. Instagram followers grew to 999. There were 70,745 hits to the PCAK website.

PCAK evaluates the resource library using tracking and distribution databases. Consumer satisfaction surveys and inferential statistics are utilized as well to determine the needs of consumers throughout the state:

- The most requested informational brochures continue to address pediatric abusive head trauma, child sexual abuse prevention, and the role of every person to report suspected child abuse and neglect. They are, "Hold Them, Hug Them, Love Them but Never Shake a Baby", which reflects the intentional focus within PCAK and other advocacy organizations in addressing high instances of pediatric abusive head trauma in Kentucky; "Preventing Child Sexual Abuse", reflecting PCAK's statewide focus on child sexual abuse prevention; and "What Everyone Should Know about Child Abuse", reflecting the need for education of what to look for and how to report.
- The agency has a wide variety of resource available, and at times has difficulty meeting the demand. The agency is using technology to assist in providing this information in a more efficient and cost-effective means. This need has driven the PCAK agency goal to make the Information and Data Center Kentucky's premier source for child abuse and neglect prevention information. The Center informs Kentuckians via data, research findings, national and state trends and best practices; and will

uses all media formats to inform the public of PCAK programs, trainings, and child abuse prevention initiatives. https://www.pcaky.org/information-and-data

Prevent Child Abuse Kentucky (PCAK), Fatherhood Initiatives

PCAK has provided community services and education geared toward greater engagement of fathers for over 15 years, particularly around child abuse prevention. The focus of PCAK efforts has been on improving outcomes for children by enhancing the engagement of fathers. PCAK strives to engage local and statewide partners in efforts to raise awareness on the importance of fathers in improving outcomes for children and the need for a cross-systems approach to enhancing the community's capacity to effectively engage fathers.

PCAK seeks to address the engagement of fathers through trainings and community events. Staff have developed specific curricula to address the importance of fatherhood engagement. These trainings highlight the importance of involving fathers in children's lives, addressing all outcomes in the areas of safety, permanency, and well-being. These trainings are provided in various settings, and in partnership with agencies such as public health, local government, etc. Similarly, PCAK staff have also been engaged in community events promoting the value of father engagement. These events include activities such as community baby showers, social media posts, and fatherhood celebrations. PCAK also provides opportunities for locally and nationally recognized presenters to teach community partners and providers best practices in working with and serving fathers.

PCAK benefits from strong partnerships with agencies across the state. Partnerships cultivated throughout the state assist in the distribution of fatherhood training and resource materials. These partnerships have been particularly important as PCAK has been a leader to create a statewide collaborative, the Kentucky Fatherhood Initiative (KFI), to enhance service delivery and eliminate barriers facing fathers in the child welfare and other systems. These efforts, beginning in 2016, have involved meetings with PCAK staff, community partners, and leadership from DCBS. KFI hosted the *Kentucky Symposium on Fatherhood* in May of 2017. Staff from the Facilitation Center of Eastern Kentucky University facilitated the symposium, held in Frankfort. The Symposium was attended by representatives from the Governor's Office, CHFS, Department of Corrections, state university staff, local service providers, etc.

As an outgrowth of this effort, PCAK staff have continued to provide leadership to statewide entities and is assisting in the development of a strategic plan to move this collaborative effort forward. KFI applied for a grant funded by the Fatherhood Research and Practice Network in the fall of 2018 and was one of only 12 states chosen to receive the funding. The funding will be used to better statewide engagement of fathers in programs and policies. Planning for a summit to be held in the fall of 2019 is currently underway.

CC. Project SAFESPACE

Project SAFESPACE was a 5-year, $2.5 million grant entitled *Promoting Wellbeing and Adoption after Trauma*. The grant was funded by the Children's Bureau. The grant ended September 29, 2018. At that time, DCBS initiated a contract with University of Louisville to maintain one Clinical Consultant position through state funds.

The project is designed to enhance behavioral health services for children in OOHC through implementation of a continuum of evidence-based universal screening, functional assessment,

outcome-driven case planning, treatment, and descaling of ineffective services. Overall project goals included the following:

- Redesign of the behavioral health service delivery system;
- Reconfiguration of the infrastructure and inter/intra agency procedures to support an evidence-based continuum of screening, functional assessment, outcome-oriented case planning, and treatment;
- Universal behavioral health screening for children in OOHC by DCBS staff;
- Implementation of a functional assessment of children in OOHC serviced by PCC agencies and CMHCs;
- Assessment-driven case planning and evidence-based treatment to conduct systematic progress monitoring;
- Improvement in the social-emotional well-being of children in OOHC and those placed for adoption.

At the beginning of 2018, implementation existed in seven of the nine service regions. On June 1, 2018, the final two service regions (Northern Bluegrass and Eastern Mountains) began implementation.

The grant for SAFESPACE was held at the University of Louisville, in partnership with DCBS, DBHDID, Eastern Kentucky University, and Kentucky Partnership for Families and Children. SAFESPACE facilitates consistent meetings in a multitude of mediums with the goal of collaborative decision making. During the reporting period, SAFESPACE facilitated monthly steering committee meetings and monthly regional implementation team meetings at both the DCBS and provider levels.

SAFESPACE implementation includes a process for early identification of child trauma and behavioral health needs through standardized screening and assessment. DCBS child welfare workers administer a compilation of screeners based on the child's age upon entry into OOHC (e.g. Child PTSD Symptom Scale, CRAFFT, Strengths and Difficulties Questionnaire, Upsetting Events Survey, and Young Child PTSD Checklist). Screeners are specifically to be administered within the first 10 days of entry. For children 7 years and older the screener should primarily be informed by the child whereby information is solicited in a face-to-face interview. Screening is completed in Kentucky's Comprehensive Child Welfare Information System (CCWIS): The Worker Information System (TWIST), whereby scores are tabulated and both detailed and summary reports are generated. While screening is required for children entering OOHC it may be completed for any child served by DCBS.

Screening is designed to achieve the following: standardize decision-making and give priority for those in need of behavioral health services; inform the provider about child and family needs, alert the child welfare worker as to the child's perception of experiences, and engage caregivers and youth around assessment and treatment needs, and support leveling and placement.

Children identified as needing a standardized clinical assessment receive a provider completed Child and Adolescent Needs and Strengths (CANS) Assessment. Kentucky is currently using both the younger and older child versions of the CANS (i.e. ages 0-4 and 5-17 years). The Kentucky CANS assesses 6 domains, 69 items for younger children, 6 domains, and 79 items for children ages 5 and older. Providers have 30 days to complete the initial CANS and then update the CANS every 90 days. Providers complete the CANS in a web-based application that interfaces with TWIST. Through an automated data push and pull between, and the CANS web-based application, child demographic information remains consistent across the systems ensuring data integrity. In return high level assessment information is

communicated directly back to the DCBS child welfare worker in the form of a report detailing significant areas of concern, strengths, change over time, recommended evidence-based practice and intensity of service. This streamlined approach allows for efficient information sharing and aggregate data matching aligning child needs and treatment with child welfare outcomes. DCBS workers are trained to use CANS results to better understand clinically identified treatment needs and monitor progress. Assessment results are to be used to engage caregivers and youth, communicate with providers and partners, and incorporated in case planning at the 90-day family team meeting.

Rates of compliance in regards to completion of the screener and CANS assessment were analyzed for each region since implementation. The table below describes the number of children in OOHC, the number of children screened, the number of children who needed a CANS assessment based on screener results, and the number who received a CANS assessment. Below the table, implementation dates are listed by region.

Region	# Entered OOHC	# Children Screened	% Children Screened	# Screened in for CANS	% Screened in for CANS	# Children at least 1 CANS	% at least 1 CANS
Eastern Mountain	196	193	98.47%	120	61.22%	58	48.33%
Northern Bluegrass	484	450	92.98%	320	66.12%	149	46.56%
The Lakes	749	690	92.12%	407	54.34%	173	42.51%
Two Rivers	1274	1092	85.71%	711	55.81%	378	53.16%
Cumberland	1423	1362	95.71%	801	56.29%	404	50.44%
Jefferson	1234	1083	87.76%	631	51.13%	255	40.41%
Salt River Trail	2108	1883	89.33%	1046	49.62%	512	48.95%
Northeastern	1255	1083	86.29%	614	48.92%	342	55.70%
Southern Bluegrass	1580	1453	91.96%	721	45.63%	286	39.67%
TOTAL	10,303	9289	90.16%	5371	52.13%	2557	47.61%

SAFESPACE Implementation Dates

- Eastern Mountain and Northern Bluegrass: June 1, 2018
- The Lakes: November 1, 2017
- Two Rivers: August 1, 2017
- Cumberland: April 1, 2017
- Jefferson: April 1, 2017
- Salt River Trail: September 16, 2016
- Northeastern: November 1, 2016
- Southern Bluegrass: April 1, 2017

The following screeners are administered to children under five entering OOHC in the process described in 2b.1: Young Child PTSD Checklist (ages 0-6) and the Strengths and Difficulties Questionnaire (ages 2 and older). Children identified as needing an assessment receive a Child Adolescent Needs and Strengths Assessment (CANS). The younger child CANS has a minimum of six domains and 69 items.

All children entering OOHC during the reporting period in the implementing service regions were targeted for screening. Any child identified through screening as needing a CANS assessment and served by a community mental health provider or a private child caring/placing agency within an implementing region should have received a CANS assessment.

KAR was revised to permit use of SAFESPACE tools (i.e. screeners and the CANS) for purposes of private child caring/placing levels of care. This change will allow for reduced duplication and greater efficiency.

The project received ongoing technical assistance and support from the Administration for Children and Families' federal officer.

Evaluation activities continued during the reporting period and included qualitative measures such as DCBS and clinical case reviews, staff focus groups and surveys specific for measuring the impact of training and perceptions around implementation and collaboration. Quantitative data analysis assessing mental health/emotional well-being and safety and permanency outcomes also occurred.

Child welfare outcome differences have been noted between the SAFESPACE and non-SAFESPACE populations starting with the project's inception (i.e. 2016) and running through the end of the reporting period. Children affected by screening and assessment were found to have fewer placements and shorter lengths of time in care. Differences were not only statistically significant but also remained consistent when controlling for the length of time a case was open. More information is needed before outcome theories may be applied; however, anecdotally is it known that this population is subject to enhanced clinical attention and oversight. CANS scores are also decreasing over time, which shows an improvement in functioning for children who have been impacted by screening and assessment.

Evaluation results during this time also yielded evidence indicating DCBS workers have increased levels of support for evidenced-based practices and enhanced perceptions of collaboration with behavioral health providers. DCBS training on the clinical assessment process and items as well as the real-time electronic transmission of the assessment report to TWIST are factors accounting for perceptions.

Full-scale implementation has been achieved and efforts are now focused on full integration into casework and treatment planning. The workforce needs continued education around way to incorporate recommendations for evidence-based treatment into case planning. Additionally, independent providers serve many children in OOHC. These providers are being trained in the CANS assessment so they can also provide assessments for children in OOHC in an effort to increase CANS compliance and ensure all children who have screened in for a CANS assessment receive the assessment.

Barriers continue to exist related with the length of time needed for full engagement and education of the workforce. In addition, project time is challenged by the ongoing attention is needed to ensure fidelity to protocols and quality assurance.

DD. Rape Crisis Centers

The Kentucky Association of Sexual Assault Programs (KASAP) provides specialized services to victims of sexual violence and their friends and family members through a network of 13 regional rape crisis centers (RCCs). The RCCs cover all 120 Kentucky counties and operate on a regional model, with each center covering anywhere from 5 to 17 counties. The area development district (ADD) model was used as the template for RCC coverage. Each RCC is statutorily mandated to provide crisis counseling, mental health services, advocacy services, consultation, public education, and training programs for professionals. Services are made available free of charge and are provided to adult and child survivors of sexual violence, including those who experience an acute incident and those who were victimized in their past. CHFS has a memorandum of understanding with KASAP to administer the funds that CHFS receives for rape crisis work. The state fiscal year 2018 contract includes state general funds in the approximate amount of $4.2 million, as a group; $485,944 in rape prevention and education funds from the Center for Disease Control to Kentucky Department for Public Health and passed on to DCBS for the implementation of primary prevention programming, including the nation's first evaluated, evidence informed bystander intervention program (Green Dot in Kentucky High Schools); and $97,025 in preventive health and health services to further support primary prevention efforts. RCCs also write and receive several federal (i.e., Victims of Crime Act and Violence Against Women Act) and local grants (i.e. United Way, local fiscal government awards) that are not included in the contract with KASAP and are driven by each agency's board of directors' fundraising ability.

The RCCs work collaboratively with a number of partners to achieve the positive outcomes that they have observed throughout the past several years. In particular, DCBS children and their caretakers comprise 15% of new victims receiving RCC services. Close work between DCBS social service workers, RCC advocates, and clinicians provide a critical link in the well-being of DCBS children who may be in out-of-home placements due to documented abuse or neglect. RCC advocates are also members of each Kentucky County's MDT that collaboratively investigate and prosecute child sexual abuse cases. This opportunity to connect with the legal guardians of children in care improves the overall outcomes of children navigating the long journey of healing after disclosing sexual abuse. Many representatives from other child-serving or victim-serving agencies sit on various RCC boards of directors, reflecting the core mission of most communities to stop abuse from happening to their children.

Rape Crisis Center Data: Calendar Year 2018	
Service Category	**Number of Services Provided/ Persons Served**
New victims served	4,927
New family and friends served	925
Legal advocacy services: court, case management, referrals to services	1,993
Medical advocacy services: Sexual assault forensic exam (SAFE), follow-up exams, referrals for further medical treatment	1,988
Crisis calls received	2,950
Counseling sessions provided	17,044
DCBS client total	718
Prevention/education sessions (including Green Dot in Kentucky high schools)	3,099
Prevention/education participants (including Green Dot in Kentucky high schools)	95,681

Volunteer hours	65,384

EE. Safe Infant Services

KRS 405.075, part of "The Representative Thomas J. Burch Safe Infants Act," provides that a person may leave a newborn infant less than 72 hours old with an emergency medical services provider, police station, fire station, hospital, or participating place of worship. This Safe Infants Law states that the parent will not be criminally prosecuted for abandoning an infant less than 30 days old, if the baby is taken to one of the above-determined safe places and has not been physically abused or neglected after birth. The parent may voluntarily provide information about the baby. Within 30 days of the baby's abandonment, the parent may ask for the baby's return, and DCBS may provide services to the parent to help the family stay together and safe. After 30 days, the DCBS will begin the process of terminating the parental rights and making the child available for adoption. The statutory provisions afford parents a safe and anonymous option when they are unable to care for their newborn children. The provisions also help children obtain more timely permanency.

DCBS continues to receive requests for safe infant brochures and packets from community agencies. The requests are routed to the state Board of Emergency Medical Services that compiles hospital packets and mails them to requestors. DCBS continues to have several requests for these packets from law enforcement, fire departments, and hospitals. The program's information and downloadable posters are also available on DCBS' internet site, https://chfs.ky.gov/agencies/dcbs/dpp/cpb/Pages/safe-infants-act.aspx. The site also contains a PowerPoint presentation updated in 2016 by the state Board of Emergency Medical Services.

Because of amendments to the Safe Infant Act in the 2016 legislative session, DCBS began working with partners at Prevent Child Abuse Kentucky (PCAK) and Norton Children's Hospital to increase awareness of the program. This included meeting with the founder/president of AMT Children of Hope Foundation in New York, Mr. Jaccard, who is considered the "father" of the national safe haven initiative (http://www.amtchildrenofhope.com/index.php). Mr. Jaccard has shared information and resources, including signage, hospital protocol manual, and access to his AMT Children of Hope Foundation hotline that offers assistance 24 hours per day/7 days per week to pregnant and new mothers who are considering a safe infant placement for their child. In collaboration with PCAK and Norton Children's Hospital, DCBS has developed a hospital protocol for utilization in hospitals across the state that includes appropriate signage to designate safe infant sites. The Child Protection Branch continues to work with these agencies to finalize the materials.

In the 2016 legislative session, amendments were made to the Safe Infants Act by extending the relinquishment period from 72 hours to 30 days after birth. In addition, the amendment added participating places of worship to acceptable safe infant sites. KRS 405.075 was amended by the General Assembly to include the following language: "(5) A staffed police station, fire station, hospital, emergency medical facility, or participating place of worship may post a sign easily seen by the public stating that: "This facility is a safe and legal place to surrender a newborn infant who is less than 30 days old. A parent who places a newborn infant at this facility and expresses no intent to return for the infant shall have the right to remain anonymous and not be pursued and shall not be considered to have abandoned or endangered their newborn infant under KRS Chapters 508 and 530."

History
(2002-2018)

- There have been 49 safe infant incidents involving 50 infants since 2002 (one incident involved a set of twins).
- Of the 50 infants, seven were delivered at home, one was delivered in the hospital parking lot, and 42 were delivered in the hospital.
    - The infant delivered in the hospital parking lot was discovered to have been left at the hospital entrance. Neglect was substantiated, but the judge determined probable cause that the child was left with the intent to leave the child according to the Safe Infant Act.
- Of these 50 infants, 34 have been adopted, one has a pending termination of parental rights, and six were returned to their parents. In one of these return-to-parent cases, the father petitioned the court for custody, which he received. In another one of the cases, the mother returned to claim the child within the 30-day period, however, the child's meconium screening returned positive for substances. An ongoing case was opened with the family to provide services. In the other three cases, the mothers returned to reclaim their child within the 30-day period. DCBS opened a case and offered services. There is also a case from 2013 in which the mother returned to reclaim the child. There were concerns about the mother's home, thus an emergency custody order was issued to DCBS. The child was placed with a relative.
- Average length of time for adoption to occur is approximately 12.12 months. One of the cases from 2007 took 37 months for adoption to finalize, and it appears this is the exception to the remainder of the data. In this particular case, the child was born with severe birth defects, and the adoptive parents were waiting for the child's surgeries and medical interventions to occur prior to adoption.
- Average length of time to termination of parental rights is 6.32 months, with three months being the shortest amount of time and 12 being the most.
- There are nine DCBS service regions in Kentucky, and each region has had a case involving safe infants. The numbers of Safe Infant Act incidents per region are as follows: Two Rivers: 21, Southern Bluegrass: 6, Northern Bluegrass: 4, Jefferson: 5 (6 infants to include one set of twins), Northeastern: 3, Salt River Trail: 3, Cumberland: 2, Eastern Mountain: 1, and The Lakes: 5.
- There were no recorded safe infant cases in Kentucky during the 2005 calendar year.
- Ages of mother (if able to identify): 15, 17, 18, 22, 23, 24, 25, 26, 27, 28, 30, 33, 34, 40, as well as 26 unknowns.
- Gender of infants: 21 males and 29 females.
- Races of infants: 22 Caucasian, 5 African American, 2 Hispanic, 1 Indian, 1 biracial, and 19 unknown/declined to disclose.
- Reasons cited for abandonment, if identified: had other kids and could not financially afford another; five infants were the product of rape; mother under age 18; already has one child and cannot handle a second one; cannot care for the child; an alternative to abortion; husband does not want the child; wants to give the child a better life; 15-year-old mother was afraid that the maternal grandfather would kill her if he found out about the baby; child had severe birth defects; mother was homeless; mother reported that she wanted to anonymously place child up for adoption; mother overwhelmed and afraid she will hurt the baby; mother concerned she would be disowned by her family due to cultural issues; parents are illegal immigrants and afraid if deported due to the new administration; and the baby will not be able to receive the medical care needed.
- One mother reported using the Safe Infants Act with a previous child.
- Health issues identified of babies at adoption: asthma, lung disorder, difficulty walking, and severely deformed infant. Most infants are healthy with no problems.

Two cases were thought to be safe infants but were reversed after circumstances changed the outcome. One case was in Southern Bluegrass and the mother returned to claim the child only to sign a voluntary

termination of parent rights later. The other case was in Two Rivers, and the mother and relative returned to claim the child and request placement with a relative; however, there were neglect concerns and an emergency custody order was granted to DCBS. There were six cases in which the parent returned to claim the child within specified timeframes, and one of these was the natural father.

Situations that occurred that could have perhaps been avoided if the Safe Infants Act had been utilized include the following:

- An infant left in a shoebox in March 2007; however, it was left at an unoccupied duplex, and this is not a designated place.
- An infant was delivered and placed on a doorstep; the child was not considered a safe infant because the child was not left at an appropriate location.
- An infant was placed in a plastic bag upon delivery at Bellarmine College.
- Two additional fatalities that occurred in 2008 could have been avoided if the mother had utilized the Safe Infants Act.
- In 2009, an infant was left in a garbage receptacle immediately after delivery; toilet paper was stuffed in the infant's throat.
- In 2011, a teenage mother, who was subsequently charged with homicide, suffocated an infant.
- In 2013, an infant was left in a trashcan inside a department store in Louisville. The mother was initially charged with abuse of a corpse and tampering with physical evidence.
- In 2014, a mother reportedly did not know she was pregnant, delivered her infant at home, and placed the infant in a trashcan. The infant survived and criminal charges are pending. Also in 2014, the remains of an infant were located on the property of a home in deplorable conditions where nine other children were removed and the parents were charged with wanton endangerment.
- In 2015, the Safe Infant Act could have been utilized in two incidents. The first occurred in January: Mother delivered the baby in a toilet. She put the child in a garbage bag and was going to put the child in a dumpster until someone intervened. The infant survived. The second occurred in July: Mother (age 15) delivered the baby at a local hospital while visiting her grandmother who was hospitalized. Mother wrapped the child in linen and put the baby in a dresser drawer. The infant did not survive, and the mother was criminally charged.
- In November 2017, a deceased infant was located inside of a bag on a busy neighborhood street in Lexington, Kentucky. The mother was never located.
- In 2018, Safe Infant could have been utilized in two incidents. The first occurred July when a mother delivered her baby at home. The infant was deceased upon arrival to the hospital. The autopsy concluded that while the child was born alive, the results were suggestive of multiple scenarios, including heat exposure, smothering/suffocation, and neglect. Due to this information, the cause of death was determined to be homicide. The second occurred in December when a baby was found in a garbage bag outside an apartment complex. An autopsy showed the baby had cranial bleeding and fractured ribs. The infant did not survive, and the mother was criminally charged.

FF. Safety Net

Safety Net is a short-term intervention program that provides services to former recipients of TANF cash assistance who are no longer eligible for assistance due to failure to comply with participation requirements or reaching their 60-month lifetime limit of receipt. The goal of Safety Net is to prevent out-of-home placement of children in these families. The program is funded through Title IV-A and services are administered statewide.

Services are designed to assist families in developing the skills necessary to manage their home and family relationships while preventing home disruption. Activities include assessment of the family and home; problem solving; and intervention in crises including utility shutoffs or insufficient food, clothing, housing, or employment. Referrals to community resources may also be made to meet any immediate needs the family may have.

Staff from the Division of Family Support notifies DPP staff when a family is no longer eligible for TANF cash assistance due to failure to comply with participation requirements or reaching the 60-month lifetime limit of receipt. Within 15 days, DPP staff contacts the family to arrange a home visit to complete an assessment. After the completion of the assessment, DPP staff may help the family develop a plan of action and refer the family to community resources to assist in meeting any unmet needs of the family. If financial assistance is needed and the family is at or below 200% of the federal poverty level, the family may receive up to $635 for over a 4-month period within the 12-month period following discontinuance. These benefits are used to meet basic needs such as shelter, food, clothing, or utilities.

Each service region is allocated a specific amount of Safety Net funds. A monthly log containing the names of the families, the purpose and amount of expenditures, names of families denied, and the resources utilized is maintained in each local office. In addition to the monthly log, staff document how Safety Net prevented out-of-home placements and family instability. A copy of the regional log, invoices, receipts, and checks issued are submitted each month to the Division of Administration and Financial Management.

From January 1, 2018 through December 31, 2018, 51 families received Safety Net services. This was an average of four families per month, and $1,379.70 per month. Safety Net referrals for January 2019 have begun.

There have been no changes in policy or practice during the calendar year of 2018. CHFS intends to continue to provide Safety Net services for families who lose TANF benefits to prevent out-of-home placement of children and to assist the family in maintaining stability.

GG. Sobriety Treatment and Recovery Teams

The Kentucky Sobriety Treatment and Recovery Teams (START) program is an intensive intervention model for substance using parents and families involved with the child welfare system that integrates substance use disorder and recovery services, family preservation, community partnerships, and best practices in child welfare and substance use disorder treatment. The program aims to address systems issues that result in barriers to families being able to access services in a timely manner. It requires an approach to service delivery that involves cross-system collaboration and flexibility to meet the unique needs of this population.

Kentucky START is based on the successful and nationally recognized Sobriety, Treatment, and Reducing Trauma (START) program in Cleveland, Ohio. Kentucky began implementing START in 2007 and has modified and evolved the model to fit the needs of Kentucky families. Daviess County was awarded federal funding to implement START and state and federal funding is being used to fund the program in four other counties in Kentucky: Kenton, Jefferson, Boyd, and Fayette. A fifth site in rural Martin County had federal grant funding for 6 years and has now shifted to a less intensive model. As part of Kentucky's Title IV-E Waiver, START is being expanded. Jefferson County and Kenton County added a

second START team and Fayette County is implementing START as well. In 2019, START will be expanding to two additional sites utilizing Kentucky Opioid Response Effort funding: Campbell and Boone Counties.

The key components of START are:

- Specially trained child protective services (CPS) worker and a family mentor share a caseload of families with co-occurring substance abuse and child maltreatment where at least one child is 5 or younger with a focus on substance-exposed infants.
- The family mentor brings real-life experience to the team and is a recovering person with at least 3 years' sobriety and previous CPS involvement. She/he is rigorously screened, trained, and supervised to provide START families with both recovery coaching and help navigating the CPS system;
- Reduced caseloads for the START team of 12-15 families per worker/mentor pair;
- 12 basic tenets outline the program philosophy and collaboration;
- Integration between CPS, substance use disorder treatment providers, and community partners by addressing differences in professional perspectives;
- A service delivery model that is more frequent, intense, and coordinated, seeking to intervene quickly upon receipt of the referral to CPS;
- Quick access to substance use treatment and close collaboration among CPS and service providers;
- Shared decision-making among all team players, including the family;
- Collaboration with community partners, substance use disorder providers, the courts, and the child welfare system dedicated to building community capacity and making START work;
- Sober parenting supports that include flexible funding for meeting basic needs such as housing, transportation, child care, and intensive in-home services;
- A holistic assessment for all clients, addressing substance use, mental health, and trauma; and
- Extensive program evaluation to indicate and document the program achievements and challenges.

Specific objectives are to reduce recurrence of child abuse/neglect; provide comprehensive support services to children and families; provide quick and timely access to substance use disorder treatment; improve treatment completion rates; build protective parenting capacities; and increase the county, region, and state's capacity to address co-occurring substance abuse and child maltreatment.

In 2018, START teams served 357 families. This included 584 adults and 688 children.

In addition to direct services to families, expansion of the program, and multiple presentations and workshops at regional and national conferences, there was one new publication about START in a peer-reviewed journal. Additionally, the START program is listed on the California Evidenced-Based Clearinghouse for Child Welfare (CEBC) as a program with promising research evidence. Here is the direct link to the listing on the CEBC: http://www.cebc4cw.org/program/sobriety-treatment-and-recovery-teams/detailed. When people are looking for evidence-based programs to help families in the child welfare system, they will see START as one of their options.

While the overall START program is still partially supported by TANF MOE funds, federal grant funds, and state general funds, the expansion of Medicaid in Kentucky is now another source of funding that supports the program through paying for certain substance use disorder treatment services. By using

Medicaid to pay for treatment services, providers have been able to use less TANF MOE funds during the past year.

Additionally, Kentucky is now utilizing Title IV-E waiver funds to support the expansion of START in existing sites and to other communities. The purpose of Kentucky's Title IV-E waiver demonstration project is to further the state's progress toward the Child and Family Services Review outcomes of safety, permanency, and well-being of families and children involved in the child welfare system. Through the waiver, Kentucky aims to reduce the need for OOHC placements and shorten the duration of necessary OOHC placements through the expansion of the START program. As of October 2015, Jefferson START expanded from one team to two teams and served families under the Title IV-E Waiver. Kenton County also expanded from one team to two, and Fayette County began serving families in January 2017. Boyd County also began serving families under the IV-E waiver in July 2017 and Daviess County began serving families under the waiver in July 2018.

In summary, several funding streams help pay for and sustain START:

- TANF MOE
- State general funds
- Federal grant funds
- Medicaid
- Title IV-E waiver funds

Starting in 2007, $2 million of TANF MOE funds has been provided each year and allocated into contracts with the CMHCs that provide services for START and Solutions and additional funds are contracted to Eastern Kentucky University to employ family mentors and program managers. START in Martin County was funded through a federal Regional Partnership Grant (RPG) through the Administration for Children and Families ($2.5 million over 5 years). This federal funding ended in June 2012. Due to the fiscal climate, there were no funds to sustain the full START model in Martin County, so the program officially ended in that county in June of 2013. This site does, however, continue to utilize one of the major START strategies. A family mentor remains in Martin County to assist and engage families in getting into services, specifically substance use disorder treatment. This mentor works with all staff in the DCBS office, taking referrals for families who have co-occurring child maltreatment and substance use.

In October 2012, DCBS was awarded another federal RPG through the Administration for Children and Families to implement START in Daviess County. This was a 5-year grant providing $2.5 million through the life of the grant. State general funds were also used to fund portions of this program. This grant ended in October 2017 and the program was granted a no-cost extension through September 2018. In July 2018, the program changed contracted behavioral health providers at that site. With the change happening so close to the end of the RPG and because the intention to sustain START services in Daviess under the Waiver, it was decided that the behavioral health contract would not be funded with RPG funds, but instead funded with IV-E waiver funds for the entirety of the state fiscal year. The change allowed for a transition to the sustainability plan. Contractual items in the EKU budget, such as family mentor salary and fringe, travel, training, statewide meetings, and evaluation through the University of Louisville, continued to be funded with RPG no-cost extension funds through September 30, 2018, at which time all of those items moved to the IV-E Waiver as well.

All START sites participate in a process evaluation that regularly monitors fidelity to the START model. Specifically, sites are evaluated on how quickly: (1) families are referred to START; (2) the first family

team meeting is conducted; (3) adults are assessed by the drug treatment provider. Other process outcomes, such as retention and intensity of treatment, are regularly assessed.

The rigorous outcome evaluation for START includes all START sites. Daviess is an RPG site and participating in a national cross-site evaluation, which will compare outcomes for START clients from each site with a matched comparison group. As part of the Daviess evaluation, a larger evaluation will be conducted with children served by START between 2010 and 2017. This evaluation will report on recurrence and OOHC outcomes for 524 START children (the youngest child in 524 START families) and 524 matched comparison children. This quasi-experimental evaluation used propensity score matching to establish comparison group based on the following variables: county of residence, child age, child race, child gender, investigation finding, year of event, parental mental health, domestic violence, poverty, criminal history, and substance use.

Jefferson, Kenton, Boyd, and Fayette Counties are also a part of the KY Title IV-E Waiver Demonstration Project evaluation, which includes a randomized controlled trial in Jefferson County. Between October 1, 2015 and September 30, 2018, 337 families were randomized (226 to START, and 111 to control; approximately 45 families were accepted into START and subsequently determined ineligible, so the number of START families will be closer to 181). The evaluation for Kenton and Fayette Counties will involve matched comparison group, as described above. Additionally, Jefferson, Kenton, and Fayette Counties are collecting primary data at baseline and at 12 months on a number of outcomes for both START families and a control or matched comparison group receiving standard DCBS services. Both process and outcome evaluation activities rely on a mixture of primary data collected by the evaluation team, service data entered by START teams, and data from TWIST.

FFPSA has been a focus for Kentucky with the child welfare transformation efforts. START leadership is aligned with these efforts and participating in workgroup discussions and planning. Additionally, START leadership and a START family mentor will be participating in the Child and Family Services Plan Continuous Quality Improvement Stakeholder Meeting.

Additionally, there is a large focus on developing consistent practice guidelines in the area of substance-exposed infants and how to address neonatal abstinence syndrome. START leadership is involved in the state's plan of safe care in an effort to ensure compliance with the Child Abuse Prevention Treatment Act. Along with this is the need for a philosophical stance and vision alignment of DCBS leadership, behavioral health treatment providers, the courts, and the community on how the state will address medication-assisted treatment (MAT), as well as work with families who have opioid addiction, a substance-exposed infant or are dealing with neonatal abstinence syndrome. START leadership is working with central office to discuss these matters and give input on best practice in these areas with a goal to provide consistent guidance to the entire state on these matters. The START directors did a training for central office staff in the area of practice guidance around working with families on MAT in the child welfare system and continue to hold regional trainings around this issue.

Technical assistance and consultation are provided regularly by the Children's Bureau for the RPGs. Additionally, the National Center on Substance Abuse and Child Welfare provides technical assistance to all RPG grantees, and provided through the end of the grant period. The START program works closely with both of these entities and they have both been extremely helpful in supporting the growth and sustainability of START in Kentucky. Additionally, START received technical assistance from Children and Family Futures around fidelity to the model, hiring, coaching of new leadership, and evaluation.

The START Jefferson County Title IV-E evaluation provides an opportunity to contribute to evidence-based child welfare practices. By conducting a randomized control trial of the program, the evaluation will establish new knowledge about the impacts of the START program with high-risk families. Establishing a sufficient control group is critical to the success of the randomized control trial and the program evaluation remained a challenge.

The evaluation team conducted multiple brief meetings with the investigative teams in Jefferson County. During 2016 and 2017, the evaluation team conducted the meetings to achieve the following objectives: (1) introduce themselves and provide an overview of the START evaluation; (2) describe the type of assistance needed from investigative teams to recruit control group families (e.g., contact information for the family, information about when the family may be at a DCBS office so the data collector could recruit the family in person, and any other relevant suggestions for making contact with the family); and (3) provide a small gift (i.e., coffee mug) to all investigative supervisors and workers. Unfortunately, the meetings did not yield a consistent stream of referrals. The team continued to work on increasing the amount of referrals by continued education and communication with regional leadership and front line staff in Jefferson.

Recruitment of participants for primary data collection remained challenging in Jefferson, Kenton, and Fayette Counties up to the conclusion of primary data collection on November 30, 2018, despite attempts to improve systems for generating referrals. Twelve-month follow-up data collection efforts are ongoing in Jefferson, Kenton, and Fayette Counties.

The expansion and implementation of a second START team in Jefferson and Kenton Counties and a new team in Fayette have been far more difficult than program directors and the evaluation team had anticipated. A significant barrier has been fully staffing the teams as well as ensuring that all eligible families are referred.

Workforce issues have affected the ability to staff the teams with experienced workers. The Jefferson START teams have had many changes in workers since expansion in 2015, with workers leaving the agency or moving to other teams due to not being a good fit. Additionally, due to the vacancies in the investigative units, the ability to transfer experienced staff has been limited. The team has now begun to stabilize, although still not fully staffed.

High turnover of investigative staff as well as a workforce of new investigative social workers, the initial source of START referrals, continues to be a barrier to receiving a consistent stream of referrals to the program despite high numbers of eligible families. This has continued to cause the need for additional education in regards to START at both a worker and supervisory level. START program directors and supervisors have offered continuous training and have developed materials to educate investigative staff on START criteria and the referral process. The START supervisors continue to meet with the investigative teams to reinforce the referral process and the new target population. A recent training was held with investigative supervisors and two sessions are scheduled for investigative staff. Additionally, a START referral form was developed with a goal of increasing referrals and reducing the need for follow up questions.

There are currently ten investigative teams taking referrals that could be potential START cases. The region has been reporting plans to develop a specialized investigative team that would take referrals with allegations of parental substance use and child maltreatment. However, due to leadership changes, this effort has not moved forward. START leadership has expressed support for this plan and

would ensure that staff on the team were invited to trainings and other meetings with START staff to support them in implementation and ongoing.

Fayette County has also experienced staffing changes that have affected implementation. The START supervisor needed to be out of the office frequently and it was realized that more consistent supervisory support for the team was needed. Another experienced supervisor, familiar with START, recently took over supervision for the team and she is being provided training and ongoing coaching and support. The team has experienced a high amount of turnover since implementation, so the focus has needed to be on staffing, training, and fidelity to the model. Recruitment efforts remain underway to fill a family mentor position.

Referrals to START have also been an area of focus in Fayette County, as it does not appear all eligible cases are being referred. Additionally, the shift to a shared decision making model and safety planning to keep children in the home has taken some time. The START supervisor and directors have met with the investigative supervisors and have completed training for investigative staff. Leadership for the investigative teams are now participating in steering committee meetings to discuss these issues. Referrals have improved and the dialogue around in home safety plans is shifting.

Kenton County is experiencing workforce issues as well which have affected expansion. Staffing of the teams has been a focus for the START leadership and regional leadership. Due to staffing shortages in the region, it took some time to get the worker positions filled. Additionally, family mentor recruitment was a challenge for a period. The team is beginning to stabilize but is not yet fully staffed.

Kenton County is also experiencing barriers to receiving consistent START referrals when the volume of eligible families are present. Due to challenges with low numbers of START referrals, the plan is to shift one of the two new worker positions to an investigative position for a period, until START caseloads increase. Additionally, the investigative leadership in this region is also attending the monthly steering/expansion meetings and working to identify barriers to early identification of cases and making timely referrals to START. The START supervisors are also meeting weekly with the investigative supervisors to review all referrals received, and continue to provide coaching and training for investigative staff around the START model and referral process.

Boyd County has had some shift in workers as well but will soon be fully staffed with START workers. Recruitment of family mentors has been a challenge. One family mentor positions remains vacant at this time. Recruitment and hiring of family mentors will continue to be an area of focus for Boyd County.

Daviess County has had some changes in staff on the team but the region has prioritized filling these positions. Training and coaching for new staff has been the focus to work towards serving additional families with fidelity to the model.

Jefferson and Kenton County have experienced leadership changes over the last year. START directors work collaboratively with regional leadership at all START sites as well as leadership in central office. START directors have increased contact with regional leadership in all regions to ensure a focused time is available for START leadership and regional leadership to provide any updates, address challenges, and collaboratively support direct supervisors for the START teams.

The START program continues to work on implementation of START in Jefferson, Fayette, and Kenton Counties giving much thought and planning about how to address the current workforce barriers with the assistance of regional leadership. The process evaluation for the program will also address and document the impact these factors have on the overall expansion and implementation process. Discussions and support for staff around areas identified as challenges, including the opiate epidemic and treating the unique needs of those families impacted by methamphetamines, will continue to occur.

HH. Social Services Block Grant

States are able to consolidate a number of programs into a single grant under the Social Services Block Grant (SSBG). SSBG is funded through Title XX of the Social Security Act. Federal grant awards for each state are determined by a statutory formula based on the state's population. States have the flexibility to determine what services will be provided, who is eligible to receive the services, and how funds are to be distributed. Services are available statewide and are directed at one or more of the five national goals:

- Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;
- Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;
- Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families;
- Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and
- Securing referral or admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions.

SSBG services are used to support, in whole or in part, the state mandated social services programs administered by DCBS. When feasible, services are purchased through written agreements with service providers throughout the state. The following is a list of providers contracted to provide services for adult protection, child protection, residential services (for juveniles), and training: DJJ, Eastern Kentucky University, KCADV, Seven Counties and, the University of Louisville.

Kentucky's CCWIS (TWIST), captures the number of clients receiving SSBG services. Data generated from TWIST indicate that child protective services are supportive of the child welfare outcomes. This data is evaluated every six 6 months and is used in reporting to the Legislative Research Commission (LRC). Additional reports are submitted to the federal government annually. TWIST data reflect an increase in child protective services each year, indicating the continuing need for child welfare services statewide.

Calendar Year 2018 Data	
SSBG Service	**Number of Clients Served**
Adult/Domestic Violence Protection	132,500
Child Protection	427,837
Home Safety Services	4,827
Juvenile Services	3,198
Residential Treatment	512

- <u>Adult/Domestic Violence Protection</u>
  Provides protective services to adults designed to prevent and remedy abuse, neglect, or exploitation; increase employability and/or self-sufficiency; or prevent inappropriate placement (e.g. investigate complaints of abuse, provide supportive services, or counseling).

- Child Protection
  Provides children and their families with services designed to prevent or remedy abuse, neglect, or exploitation (e.g., identification of children at risk; investigation of reports of abuse, neglect, or dependency; removal of the child from the home when necessary; or information and referral services).

- Home Safety Services
  Provides services to prevent the removal or repeat maltreatment of a child, or to maintain an adult's safety in the home or community (e.g., arranging for community agencies to provide help with day-to-day household tasks; instructing and assisting with meal planning; nutrition; budgeting; or general household management).

- Juvenile Services
  Provides children and their families with services designed to prevent or remedy abuse, neglect, or exploitation, and to help prevent the youth's future involvement with the juvenile or criminal justice system (e.g., interaction with courts on behalf of juveniles; counseling; psychological testing and/or psychiatric consultation; or utilization of appropriate resources).

- Residential Treatment Services
  Provides a comprehensive treatment-oriented living experience, in a 24-hour residential facility for juvenile offenders committed to CHFS or DJJ. These services are provided through a written agreement with DJJ.
- Staff Training
  Provides ongoing training for DCBS staff that addresses the skills and knowledge base necessary to carry out their duties with regard to services provided by the SSBG programs.

II. Solutions

Solutions is an intensive treatment and support program serving Breathitt, Knott, Lee, Letcher, Owsley, and Wolfe Counties that works intensively with female clients to address substance abuse, mental health, intimate partner abuse, and/or other victimization issues. Solutions initially served only female clients but expanded services to serve males in several of the counties using the same model. The majority of the project's clients are parents who are DCBS DPP clients with the goal of keeping children in the home and/or reuniting children with their parents.

Participants in the program receive group and individual treatment for both substance use disorders and other behavioral health issues. They have the opportunity to earn a general education diploma (GED), learn employment and interview skills, and develop parenting skills. The program considers the unique history of women in the area and includes trauma-sensitive practices. All programs implemented through Solutions are evidence-informed practices, such as the Seeking Safety and Nurturing Parenting programs. Participants are transported to the treatment services as needed.

The program also provides case management/case coordination and advocacy services to assist clients in accessing domestic violence shelter services, legal services, medical services including psychiatric care, safe and sober housing, education and employment, and services for their children. Solutions staff members also provide onsite parenting classes for the clients. The staff participates in family treatment team meetings, case collaboration meetings, and ongoing case reviews. DCBS and the courts are provided weekly progress reports on referred clients.

Starting in 2007, $2 million of TANF MOE funds have been provided each year and allocated into contracts with the CMHCs that provide services for START and Solutions and additional funds are contracted to Eastern Kentucky University to employ family mentors and program managers.

JJ. Targeted Assessment Program

The Targeted Assessment Program (TAP) is a nationally recognized Kentucky model for assisting parents involved in public assistance and child welfare systems overcome multiple barriers to self-sufficiency, stability, and safety within federally mandated timeframes. For the past 19 years, DCBS has collaborated with the University of Kentucky to provide TAP services. The TAP model co-locates professional targeted assessment specialists (assessors) at public assistance and child protective services offices in Kentucky counties designated by DCBS. TAP assessors conduct client assessments in four primary areas – substance use, mental health, intimate partner violence victimization, and learning problems – as well as other barriers for families including housing, transportation and other basic needs, physical health problems, legal difficulties, and deficits in education and employment.

Mental Health

The mental health assessment includes questions from the Mini International Neuropsychiatric Interview (M.I.N.I.) and Breslau's 7-Item Post-Traumatic Stress Disorder (PTSD) Screening Scale which measure: depression, suicidal ideation, anxiety, mania, PTSD, and thought disorders. History of childhood (under age of 14) neglect, emotional abuse, physical abuse, sexual abuse or assault, and foster care placement is assessed along with any history of treatment for mental health problems. Mental health problems are defined as "having an acute episode of a mental illness in the past year, having a chronic mental illness, or having a severe and persistent mental illness" (SPMI).

Substance Use

Substance use disorders are also assessed in TAP. The assessor asks about current and past substance use, the amount of use, the consequences of use, the physical and psychological impact the use is having on life, and the need for current treatment. Questions include lifetime and past 3-month use of specific legal and illicit substances – tobacco, alcohol and prescription medications, indicators of substance abuse and dependence, as well as history of treatment, including DUI classes and self-help groups. The substance use assessment incorporates questions adapted from the Addiction Severity Index (ASI), as well as substance misuse and dependence screens. Substance use problems are operationally defined as "the use of drugs or alcohol which affects social, physical, cognitive, legal, or occupational functioning."

Intimate Partner Violence Victimization

Intimate partner violence (IPV) victimization is assessed by asking each person his or her previous experiences with emotional, physical, and sexual abuse in intimate relationships, and current risk of harm by an intimate partner. Lifetime and past 3-month measures for 21 indicators of abuse and violence are used, as well as the history of services for IPV. TAP assesses risks of the person's current situation and assists with safety planning. IPV victimization measures include questions adapted from the Conflict Tactics Scale (CTS). IPV is defined as "experiencing abuse or violence at the hands of a current or past intimate partner or still being troubled by the effects of an abusive relationship in the past."

Learning Problems

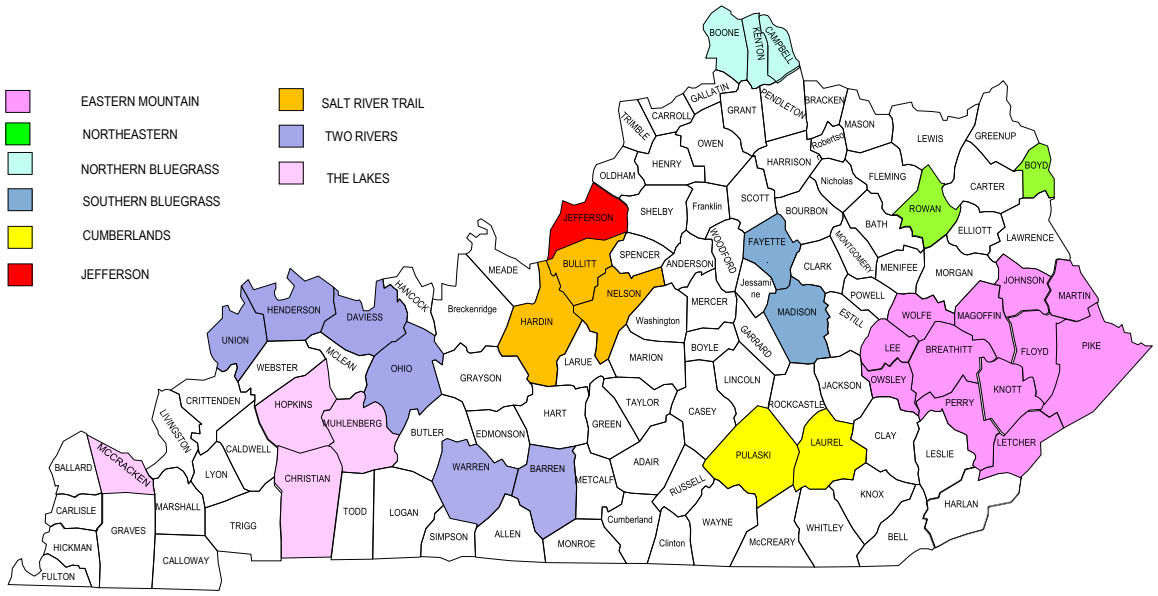
Learning problems are assessed using the Washington State Learning Needs Screening Tool to identify whether the individual may have difficulty performing certain tasks or has a family history that may indicate a learning disability. Learning problems are operationally defined as a suspected learning disability or a learning deficiency. A learning deficiency is defined as a "problem that results from a lack of education due to poor educational opportunities or family issues such as dropping out of school because of an early pregnancy." A learning disability is defined as "a neurological disorder that impairs the brain's ability to receive, process, and respond to information."

TAP is supported with TANF funds. Eligibility criteria include receipt of TANF benefits or TANF eligibility with a family income of 200% of poverty and below. Parents referred by DPP must have a child in the home or a plan for reunification. By identifying and addressing substance use and mental health disorders, IPV, and learning deficits/disabilities, TAP services support DCBS efforts to meet safety, permanency, and well-being outcomes for children. The clinical expertise and evidence-based intervention provided by TAP supports DPP in providing "reasonable efforts" to prevent removal or reunify families presenting multiple risk factors. The following services are provided in all TAP counties:

- Assessment
- Referral
- Strengths-based case management/case coordination
- Pre-treatment, including Motivational Interviewing
- Follow-up
- Consultation and training

TAP co-locates assessors onsite at the DCBS Division of Family Support and the DPP offices in 35 of 120 counties. TAP services are available in all nine DCBS DPP service regions, with the highest number of TAP counties in the Eastern Mountain and Two Rivers service regions. Kentucky's more populated urban counties are assigned higher number of assessors, but most TAP counties are more rural with lower populations and have one to two assessors. One assessor serves Lee and Owsley Counties, one assessor serves both Henderson and Union Counties, and one assessor works half time in Perry County and half time in Wolfe County. Four field supervisor positions were established in Eastern and Western Kentucky; all field supervisors are assigned approximately 50% assessor and 50% supervisory responsibilities. TAP has found that co-locating these positions regionally increases TAP efficiency and access, enhances cost-effectiveness, and ensures better communication and support for DCBS and TAP.

University of Kentucky Targeted Assessment Program, 2018 Service Map by DCBS Service Region



During fiscal year (FY) 2018, TAP facilitated or participated in 33 TAP advisory council meetings and 27 planning and implementation meetings with DCBS staff. In addition, TAP facilitated 27 local community selection committee meetings to fill TAP staff vacancies. TAP provides consultations to DCBS staff for participants who have been referred to TAP as well as non-TAP participant cases. During fiscal year 2018, TAP provided 13,668 case consultations to DCBS for TAP participants and 3,129 case consultations for non-TAP participants. In support of and in collaboration with DCBS, TAP staff participated in FTMs to engage and support the family in the case planning, case management, and case closure processes. FTMs bring together parents, families, other significant adults, and child welfare and other professionals for collaborative case planning and shared decision making. During fiscal year 2018, TAP assessors participated in 1,328 FTMs statewide. These collaborations strengthen communication between DCBS and TAP and enhance services for families. The sharing of information and expertise is an invaluable part of case planning to improve outcomes.

During fiscal year 2018, TAP completed 2,304 baseline assessments for participants referred by DCBS divisions and other sources. Referrals to TAP (n=3,347) continue to be primarily from DCBS DPP (83%, n=2,766) and DCBS Family Support (14%, n=466). Assessors also completed 3,413 case closure reports for participants who terminated TAP services during the FY. Of these terminating participants, 70% (n=2,373) had received a baseline assessment (terminating participants may have been referred or assessed prior to fiscal year 2018). Mental health and substance use were the most prevalent of the four targeted barriers, with almost three-fourths (74%) of those assessed self-reporting mental health as a barrier and more than half (57%) reporting substance use as a barrier to self-sufficiency and family safety. Notably, many participants were assessed with multiple barriers. More than two-thirds (n=1,640; 69%) of those assessed prior to termination were found to have two or more barriers, with more than a quarter (n=613; 26%) assessed with three or more barriers.

<u>Evaluation</u>

Assessors completed 3,413 case closure reports for participants who terminated TAP services during the FY. Of these terminating participants, 70% (n=2,373) had received a baseline assessment (terminating participants may have been referred or assessed prior to fiscal year 2018). Terminating participants who received an assessment had an average of nine direct contacts with TAP prior to termination, with an average duration of services of 34 weeks.

Of the 2,373 terminating participants who were assessed, over four-fifths (87%, n=1,942) showed improvement in accessing needed services. Among terminating participants who received an assessment, progress in overcoming major barriers to self-sufficiency was rated (from no progress to a lot of progress) by assessors as:

- 83% of terminations identified with mental health as a barrier made progress
- 84% of terminations with substance use as a barrier made progress
- 76% of terminations with IPV as a barrier made progress
- 46% of terminations with learning problems as a barrier made progress

When needed, TAP provides case coordination to facilitate engagement and improve access to recommended services and resources. Through case coordination, TAP assists with resolving external barriers such as difficulties with transportation, food, housing, utilities, and childcare. These external or structural barriers may be primary for some participants. For example, taking participants to housing authorities, food banks, and the gas company is often a prerequisite for further participation. Until a parent finds housing, feeds her or his children, or gets the utilities turned back on, s/he may not be able to focus on the need for other services. Assessors may teach skills such as accessing public transportation for upcoming appointments or selecting a childcare provider. Further, assessors help ensure that participants arrive for recommended services at appointed times and often attend initial participant appointments not only to model how and when to get there, but also to facilitate a connection with the provider. Among terminating participants who received assessment, the most common unmet basic needs were:

- Housing (32%)
- Transportation (30%)
- Social/family relationships (27%)
- Parenting (24%)

As presented in the table below, 86% (n=495) of those terminating TAP services who received an assessment and identified parenting difficulties (n=595) were rated by assessors as having made progress. In addition, more than three-fourths (609, 80%) of those who identified housing as a barrier (n=760) made progress; over four-fifths (545, 85%) of terminating participants identifying difficulties in their social/family relationships (n=645) were rated as having made progress; and 80% (609) of terminating participants reporting problems with transportation (n=710) improved access to transportation.

Among assessed participants terminating TAP services (n=2,373), 79% (n=1,866) were recommended for pre-treatment services and 1,692 (91%) participated. Seventy-three percent (n=1,221) of those participating in pre-treatment were rated with average to high levels of engagement. TAP recommended service coordination for 1,827 (77%) of terminating participants, of which 1,650 (90%) participated. Seventy-three percent (n=1,163) of those participating in service coordination were rated with average to high levels of engagement.

Progress ratings for other barriers, such as difficulty meeting DCBS requirements, legal difficulties, physical health problems, and childcare are also presented in the table below. No progress was rated if a participant did not engage or became disengaged, refused or was resistant to services, or if the participant could no longer be contacted. Further, if services did not exist or were not available (e.g. waitlists) or if the focus of pre-treatment and/or service coordination was to address other barriers or basic needs (e.g. housing), there may have been no progress in overcoming certain identified barriers. Participants who moved to a non-TAP county or who were unable to be contacted were rated by assessors on the last contact before termination.

As noted previously, progress ratings for each identified barrier are presented in the table below. The number of participants with a specific identified barrier is reported as well as progress made. The first barrier presented below, for example, is mental health. Among assessed participants terminating TAP services in fiscal year 2018, 1,743 reported mental health problems while engaged in TAP services. Of these 1,743 participants, assessors rated 1,480 (85%) as having made any progress (from a little to a lot) in overcoming mental health barriers. The number and percent of participants in each of the progress categories is also shown. This pattern is repeated for each barrier.

Progress in Overcoming Barriers to Self-Sufficiency among Participants Terminating TAP

	Assessed Participants Terminating TAP with Identified Barrier
Mental Health	**n=1,743[1]**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**1,480 (85%)[2]**
A Little Progress	401 (23%)
Some Progress	527 (30%)
Moderate Progress	476 (27%)
A Lot of Progress	76 (5%)
No Progress	263 (15%)
Substance Use	**n=1,340**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**1,118 (83%)**
A Little Progress	265 (20%)
Some Progress	312 (23%)
Moderate Progress	429 (32%)
A Lot of Progress	112 (8%)
No Progress	222 (17%)
Intimate Partner Violence	**n=943**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**822 (87%)**
A Little Progress	208 (22%)
Some Progress	250 (27%)
Moderate Progress	287 (30%)
A Lot of Progress	77 (8%)
No Progress	121 (13%)
Learning Problems	**n=409**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**206 (50%)**

[1] The number of assessed participants terminating TAP experiencing specific barriers is noted for each barrier.
[2] Percentages under each barrier represent the percent of participants making any progress with the identified barrier. Any progress includes a little, some, moderate, and a lot of progress.

	Assessed Participants Terminating TAP with Identified Barrier
A Little Progress	102 (25%)
Some Progress	63 (15%)
Moderate Progress	33 (8%)
A Lot of Progress	8 (2%)
No Progress	203 (50%)
Transportation	**n=710**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**481 (68%)**
A Little Progress	215 (30%)
Some Progress	182 (26%)
Moderate Progress	63 (9%)
A Lot of Progress	21 (3%)
No Progress	229 (32%)
Housing	**n=760**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**609 (80%)**
A Little Progress	190 (25%)
Some Progress	203 (27%)
Moderate Progress	147 (19%)
A Lot of Progress	69 (9%)
No Progress	151 (20%)
Child Care	**n=174**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**142 (82%)**
A Little Progress	25 (14%)
Some Progress	48 (28%)
Moderate Progress	53 (31%)
A Lot of Progress	16 (9%)
No Progress	32 (18%)
Physical Health	**n=314**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**264 (84%)**
A Little Progress	70 (22%)
Some Progress	126 (40%)
Moderate Progress	65 (21%)
A Lot of Progress	3 (1%)
No Progress	50 (16%)
Basic Needs for Children	**n=231**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**205 (89%)**
A Little Progress	48 (21%)
Some Progress	81 (35%)
Moderate Progress	70 (30%)
A Lot of Progress	6 (3%)
No Progress	26 (11%)
Providing Enough Food	**n=90**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**79 (88%)**
A Little Progress	22 (24%)

	Assessed Participants Terminating TAP with Identified Barrier
Some Progress	17 (19%)
Moderate Progress	34 (38%)
A Lot of Progress	6 (7%)
No Progress	11 (12%)
Problems Obtaining Work	**n=615**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**442 (72%)**
A Little Progress	137 (22%)
Some Progress	143 (23%)
Moderate Progress	105 (17%)
A Lot of Progress	57 (10%)
No Progress	173 (28%)
Problems at Work	**n=74**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**66 (89%)**
A Little Progress	22 (30%)
Some Progress	27 (36%)
Moderate Progress	15 (20%)
A Lot of Progress	2 (3%)
No Progress	8 (11%)
Problems with Education	**n=120**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**73 (61%)**
A Little Progress	30 (25%)
Some Progress	24 (20%)
Moderate Progress	17 (14%)
A Lot of Progress	2 (2%)
No Progress	47 (39%)
Difficulty Meeting DCBS Requirements	**n=741**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**618 (84%)**
A Little Progress	210 (28%)
Some Progress	198 (27%)
Moderate Progress	168 (23%)
A Lot of Progress	42 (6%)
No Progress	123 (16%)
Legal Problems	**n=291**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**238 (82%)**
A Little Progress	78 (27%)
Some Progress	86 (30%)
Moderate Progress	60 (20%)
A Lot of Progress	14 (5%)
No Progress	53 (18%)
Problems with Social/Family Relationships	**n=645**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**545 (85%)**
A Little Progress	179 (28%)
Some Progress	256 (40%)

	Assessed Participants Terminating TAP with Identified Barrier
Moderate Progress	99 (15%)
A Lot of Progress	11 (2%)
No Progress	100 (15%)
Parenting	**n=575**
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**495 (86%)**
A Little Progress	119 (21%)
Some Progress	189 (33%)
Moderate Progress	172 (30%)
A Lot of Progress	15 (2%)
No Progress	80 (14%)

Work readiness was identified as a barrier for 15% (n=360) of assessed participants terminating TAP services. As shown in the table below, 71% (n=257) of terminating participants identified with work readiness as a barrier were rated as showing improvement in work readiness. In addition, there was greater improvement for submitting applications for employment and obtaining employment than for participation in job training or continuing education.

Work Readiness Progress among Participants Terminating TAP Services

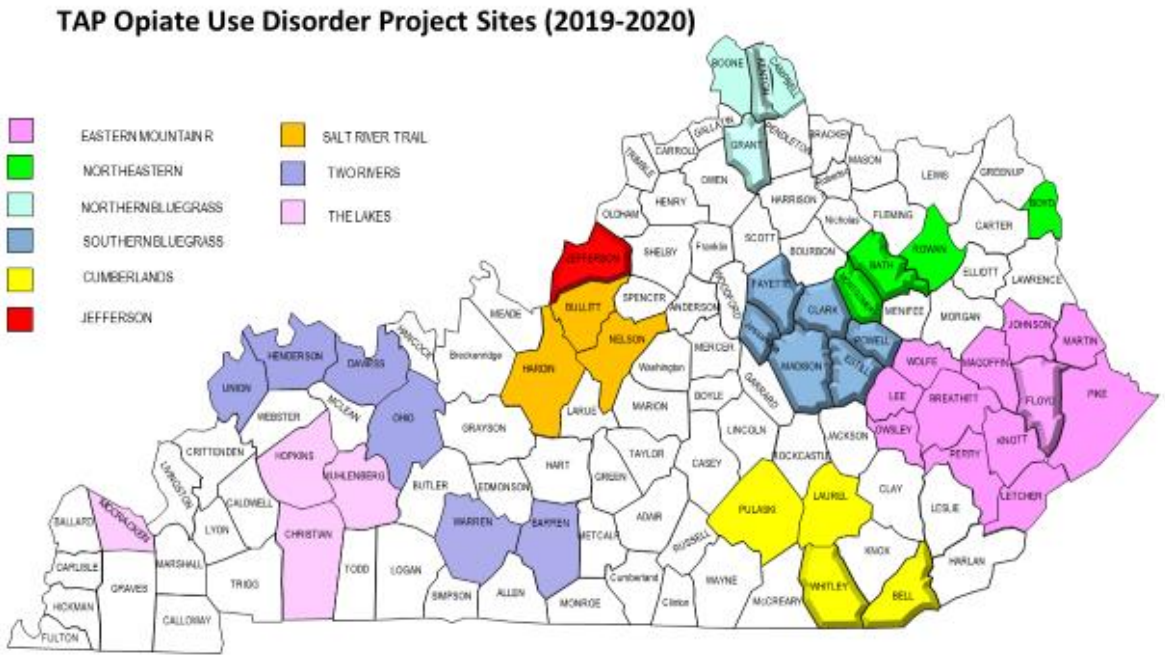
	Work readiness identified as barrier among participants terminating TAP services (n=360)
Improved Work Readiness	
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**257 (71%)**
A Little Progress	73 (20%)
Some Progress	69 (19%)
Moderate Progress	83 (23%)
A Lot of Progress	32 (9%)
No Progress	103 (29%)
Submitted Applications for Employment	
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**254 (71%)**
A Little Progress	63 (18%)
Some Progress	70 (19%)
Moderate Progress	78 (22%)
A Lot of Progress	43 (12%)
No Progress	106 (29%)
Obtaining Employment	
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**188 (52%)**
A Little Progress	46 (13%)

	Work readiness identified as barrier among participants terminating TAP services (n=360)
Some Progress	28 (8%)
Moderate Progress	61 (17%)
A Lot of Progress	53 (14%)
No Progress	172 (48%)
Participation in Job Training	
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**127 (35%)**
A Little Progress	45 (12%)
Some Progress	27 (7%)
Moderate Progress	42 (12%)
A Lot of Progress	13 (4%)
No Progress	233 (65%)
Continued Education	
Any Progress (i.e. a little, some, moderate, or a lot of progress)	**58 (16%)**
A Little Progress	16 (4%)
Some Progress	12 (3%)
Moderate Progress	20 (6%)
A Lot of Progress	10 (3%)
No Progress	302 (84%)

In fiscal year 2018, of the 2,337 assessed participants terminating TAP services, 17 participants had supplemental security income (SSI) or social security disability insurance (SSDI) applications approved with TAP assistance. An additional 81 participants had applied for SSI or SSDI with TAP assistance, and their applications were still pending at the time their TAP cases were closed.

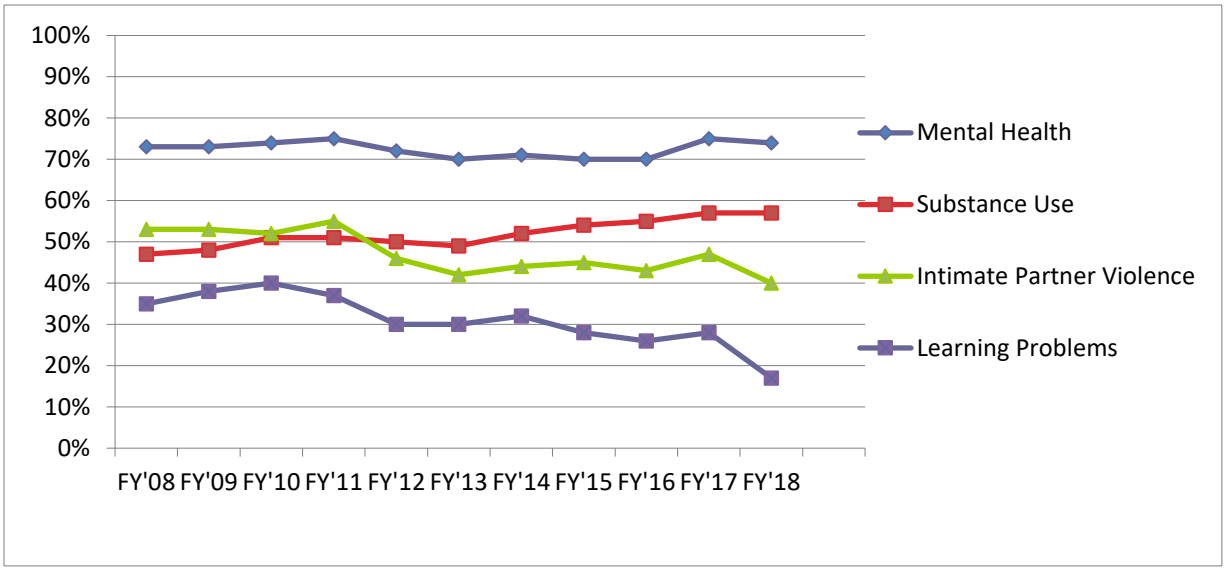
In August of 2018, DCBS invited TAP to submit a project proposal for an expansion of TAP services through DBHDID's two-year State Opioid Response (SOR) grant proposal to the Substance Abuse and Mental Health Services Administration (SAMSHA). SOR is part of the state's Kentucky Opioid Response Effort, a grant initiative already underway in the state to provide a comprehensive targeted response to Kentucky's opioid crisis by expanding access to a full continuum of high quality, evidence-based opioid prevention, treatment, recovery and harm reduction services and supports in high-risk geographic regions of the state. The TAP Opioid Use Disorder Project (TAP OUD) proposal was approved. TAP collaborated with DPP, the Division of Family Support, and the DCBS Service Regions to determine which counties to be included in the service expansion. Counties considered were those with the highest risk (Kentucky Opioid Overdose Index Score, 2017), primarily located in the Jefferson, Northern Bluegrass, Northeastern, Southern Bluegrass, Cumberland, and Eastern Mountain DCBS Service Regions. It was determined that TAP OUD Project services would be phased in, starting with counties that already have some TAP services and existing infrastructure to hasten implementation, then moving to counties that have never had TAP services. Phase One counties include Fayette, Floyd, Jefferson, Kenton, and

Madison. Phase Two counties include Bath, Bell, Clark, Estill, Grant, Jessamine, Montgomery, Powell, and Whitley. The target population is low-income parents with/or at-risk for opioid use disorder and co-occurring disorders. Using TAP's evidence-based approaches, the project's goals include increase participant engagement, reduce barriers to treatment, increase access to MAT and other community treatment services, and increase treatment retention. The TAP OUD Project will be implemented in 2019. The TAP expansion map including the TAP OUD Project sites is presented below:



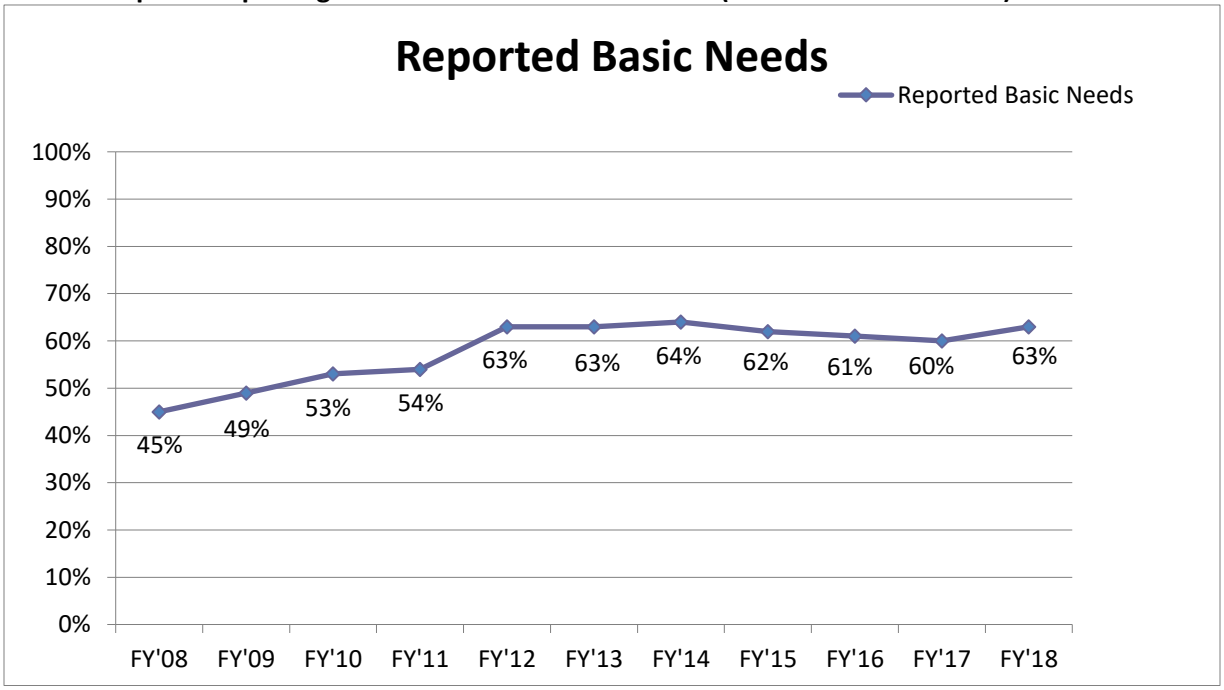
In 2018, TAP received a request from DPP to study the prevalence of barriers to self-sufficiency among TAP participants from fiscal years 2008-2018. The percent of TAP participants with barriers results is presented graphically below. Mental health has consistently been the most prevalent barrier across all years. The prevalence of participants assessed with mental health barriers increased from 70% in 2016 to 75% in 2017. The percent of participants assessed with a substance use barrier increased since fiscal year 2008, from 47% in fiscal year 2008 to 57% in fiscal years 2017 and 2018. The percent of participants assessed with an IPV barrier remained steady during fiscal years 2008-2011. The percent decreased in fiscal year 2012 due to a change in the data collection instrument implemented with the web-based system, then stabilized in subsequent years. In fiscal year 2018, 40% of participants were identified with IPV, a seven percent decrease compared to fiscal year 2017. The percent of participants screened with learning problems and deficiencies has varied year to year, ranging from a high of 40% in fiscal year 2010 to a low of 17% in fiscal year 2018.

Percent of TAP Participants Assessed with Barriers to Self-Sufficiency at Baseline (Fiscal Years 2008-2018)



The percent of TAP participants assessed with unmet basic needs barriers from fiscal year 2008 through fiscal year 2018 is also presented graphically below. The percent of participants assessed at baseline with unmet basic needs has increased from a low of 45% in fiscal year 2008 to a high of 64% in fiscal year 2014. In fiscal year 2018, the percent of assessed participants with unmet basic needs remained high and increased slightly to 63%. The most commonly identified unmet basic needs reported by participants in fiscal year 2018 were transportation, housing, social support (social/family relationships), and parenting. This is consistent with the previous fiscal year.

TAP Participants Reporting Unmet Basic Needs at Baseline (Fiscal Years 2008-2018)



In 2018, TAP received a request from DPP to survey TAP assessors on selected factors, including how well DPP workers understand client barriers, how TAP services and assessment information are utilized

by DPP, and how well DPP workers communicate and/or collaborate with TAP. Of particular interest were DPP workers' and other community members' perceived understanding of and attitudes towards MAT for opiate addiction. Availability of MAT and other services was also of interest. DPP case planning was a new area of inquiry this year, including the appropriateness of case plans as well as how well families understood their case plans. The request specified comparing findings from the current year with similar surveys conducted in previous years when possible. In addition to summarizing the findings from the survey, training needs and opportunities to improve DPP services are presented.

TAP surveyed 47 assessors co-located in DCBS offices in 34 counties in nine DCBS service regions throughout the state, with a 100% response rate for eligible assessors. Three assessors serving two different counties completed the survey once for each county, resulting in a total sample size of 50. Additionally, one assessor who was new to the project did not complete the survey, one assessor was unable to complete the survey, and there were 10 vacant TAP assessor positions at the time of the survey. The reporting period was January 1, 2018 through December 31, 2018. The survey was implemented electronically using Qualtrics Survey Solution software licensed to the University of Kentucky. The results are presented below.

TAP Utilization

Assessors were asked what percentage of their time was spent working with DPP referrals. They reported, on average, 80% of their time was spent working with individuals referred by DPP. When asked about the type of DPP referrals received, assessors reported, on average, half (50%) of DPP referrals to TAP are out-of-home cases (i.e. children removed, with possibility of reunification). More than one-quarter (28%) of DPP referrals were in-home/high-risk cases (i.e. children at risk of removal); 20% of referrals were in-home/low-risk cases (i.e. generally opened due to neglect; low removal risk). This is a change from percentages reported in previous years; overall, TAP was utilized slightly more often for out-of-home cases than for in-home cases in 2018. Assessors reported almost half (46%) of referrals to TAP were made at the beginning (i.e. intake, investigation) phase, with almost half (44%) of referrals made in the middle (on-going) phase or in the middle/ongoing phase of DPP cases. The majority of assessors (80%, n=40) rated overall utilization of TAP by DPP to be either "very good" (32%, n=16) or "good" (48%, n=24). This is a slight increase from 2017 when perceived utilization was reported by 78% of assessors as either "very good" (44%, n=23) or "good" (35%, n=18). In 2018, 16% (n=8) of assessors described DPP utilization of TAP as "fair," and 4% (n=2) of assessors reported "poor" utilization of TAP.

DPP Workers' Communication and Collaboration with TAP

Assessors reported communication between DPP workers and TAP was generally "very good" (n=20, 40%) or "good" (n=23, 46%), which were similar compared to the previous year. The percent of assessors reporting they were included in initial case planning "often" increased from 4% in 2017 to 12% in 2018, while assessors reporting they were included "more often than not" remained the same when compared to 2017 (8%). More than a third (34%, n=17) of assessors reported they were "sometimes" included in initial case planning conferences, an increase from 2017 (29%). Less than half of assessors (46%, n=23) reported they were "rarely" included in initial case planning conferences in 2018 – a decrease compared to 2017 when more than half (59%) of assessors reported they were rarely included. When asked about DPP collaboration with TAP on implementing DPP case plan objectives, over half of assessors (58%, n=29) described DPP workers' collaboration with TAP in implementing the objectives of DPP case plans as "good" (44%, n=22) or "very good" (14%, n=7), indicating a decrease since 2017. When asked how often TAP is included in Family Team Meetings (FTMs), the percentage of assessors reporting they were included "more often than not" decreased from 27% in 2017 to 23% in 2018. Those

who reported they were included "often" remained unchanged at 18% in 2018. More than half (n=29, 59%) of assessors reported they were only "sometimes" (n=21, 43%) or "rarely" (n=8, 16%) included in FTMs. This is similar to last year.

Use of TAP Information

Just under three-fourths of assessors (74%, n=37) reported that DPP staff make "very good" (30%, n=15) or "good" (44%, n=22) use of the information TAP provides, which reflects a decrease compared to 2017. The percent of assessors describing DPP staff use of TAP information as "fair" increased from 19% (n=9) in 2017 to 20% (n=10) in 2018. Assessors indicating DPP workers make "poor" use of TAP information increased from none in 2017 to 6% (n=3) in 2018. Assessors' comments indicated inconsistency among DPP staff with regard to reading and making use of assessment summary reports, monthly update reports, and other TAP consults. Assessors noted more training for DPP staff, particularly in the areas of intimate partner violence, substance use, and cognitive deficits, would help them better understand TAP recommendations. Some specific training suggestions included trauma-informed care, protective factors in active intimate partner violence situations, appropriate interventions when relapse occurs, and implicit bias.

Incorporating Understanding of Barriers into DPP Casework

Assessors were asked to rate how DPP workers incorporate their understanding of major barriers to self-sufficiency, family stability, and safety when working with DCBS clients. They reported DPP workers are most able to incorporate their knowledge into casework when addressing basic needs, and least able when addressing cognitive deficits. Ratings averaged "good" or above for mental health, substance use, physical health, basic needs, housing, child care, and legal problems and "fair" or above for intimate partner violence, transportation, support system, learning problems, educational and cognitive deficits, and employment barriers. When assessors indicated DPP workers had "poor" or "fair" understanding of at least one of the barriers, they were asked to provide comments to assist with future training.

Assessors recommended training to help workers improve attitudes toward parents with cognitive deficits, with some assessors indicating workers seem to believe parents with cognitive deficits and learning disabilities are incapable of being good parents. They also commented that workers were so busy, individuals who required a slower or different approach might be dismissed as "difficult." Assessors recommended training to help workers gain strategies, skills, and positive beliefs to enhance working with parents with cognitive deficits. Assessors also reported specific concerns about the need for improved DPP worker understanding of the obstacles commonly faced by low-income families in crisis, including basic needs barriers such as transportation and the impact multiple barriers have on parents' ability to keep appointments, visit their children, and complete goals set forth by the worker in their case plans. Further, assessors expressed the need for improved DPP understanding of the requirement that a parent obtain independent housing is sometimes an unobtainable goal. It was suggested that training address more individualized case planning to address families' housing needs and other basic needs. In addition, more in depth training on the dynamics of intimate partner violence (IPV) was recommended, including recognizing protective strategies victims may employ during active IPV. Assessors also recommended ongoing training in addiction, relapse, treatment, and the role of drug testing. Survey respondents indicated improved understanding of these and all barriers, combined with decreased negative attitudes and increased empathy toward parents, could result in more effective engagement strategies, case planning, and ongoing casework.

DPP Case Plans and Implementation of Case Plan Objectives

TAP assessors' opinions about DPP case plans were a new area of inquiry this year. Assessors were asked to rate the appropriateness of the case plan to the family's needs and were asked to rate how well the family understood their case plan. More than three-fourths of assessors (84%, n=42) indicated the appropriateness of DPP case plans for family's needs were either "good" (54%, n=27) or "very good" (30%, n=15). Further, 72% (n=36) of Assessors reported that families had either a "good" (56%, n=16) or "very good" (16%, n=8) understanding of their case plan. When asked about DPP workers' collaboration with TAP in implementing the objectives of case plans for TAP participants, over half of assessors (58%, n=29) indicated P&P workers' collaboration with TAP was "good" (44%, n=22) or "very good" (14%, n=7). This is a recurring question and indicates a decrease compared to 2017 when almost three-fourths (73%, n=38) of assessors reported collaboration with TAP in case plan objective implementation was "good" (58%, n=30) or "very good" (15%, n=8). In 2018, the percent of assessors reporting collaboration was either "fair" (28%, n=14) or "poor" (14%, n=7) increased compared to 2017.

Perceived Understanding of and Attitudes towards MAT

Assessors were asked to rate the level of "appropriate understanding" of and attitudes toward MAT for opiate addiction among three groups: DPP workers and supervisors, judges, and other community partners. Assessors reported 67% of DPP workers and supervisors, 61% of judges, and 64% of other community partners understand this treatment approach. When compared to 2017, ratings of understanding of and attitudes toward MAT among DPP staff were consistent, while ratings of understanding among judges and other community partners increased. Assessors commented that increased knowledge and understanding of MAT was directly related to education and training. Assessors were also asked to comment on overall understanding/attitudes regarding MAT among the three groups. Responses varied greatly by county. Some assessors reported that judges had become more accepting of this modality, but others reported some judges did not accept MAT as a valid form of treatment and ordered clients off MAT without consideration of the negative impact. With regard to DPP workers and supervisors, attitudes varied by county and by individual, with some workers and supervisors demonstrating appropriate levels of understanding and acceptance, while others did not. Assessors noted concern that some DPP staff and judges did not understand that MAT needed to be combined with counseling and other treatment in order to be best practice. While stigma and lack of understanding among community partners remained, assessors noted attitudes had shifted due to the opioid crisis and more opportunities for education at the community level. Overall, comments increased this year related to concern about drugs used for MAT being diverted and becoming drugs of abuse. In some regions of the state, Suboxone has become the main drug of abuse, increasing negativity towards MAT in general.

Nearly two-thirds (66%, n=33) of assessors reported that high quality MAT availability in their county/region was either "good" (54%, n=27) or "very good" (12%, n=6). Assessors in some counties indicated this treatment modality was not available within an hour's drive. Others reported that while there were many clinics or prescribing physicians in their region, the quality of treatment was poor. Some noted that negative judgment of individuals receiving MAT had decreased, but concerns about the quality of treatment had increased. Assessors having access to good quality MAT in their region also commented that "best practice" combines MAT with outpatient or intensive outpatient treatment. They found that often the counseling provided at the MAT program was inadequate so needed to be paired with other treatment services.

In 2018, assessors were also asked to rate the availability of high quality general substance use disorder treatment for the TAP participants they serve. More than two-thirds (70%, n=35) of assessors reported that the availability of high quality substance use disorder treatment in their county/region was either

"good" (48%, n=24) or "very good" (22%, n=11). Since this question was not asked previously, there was no means of comparison.

Reunification

TAP involvement in reunification planning decreased in 2018. When asked how often TAP was included in transition planning for reunification, less than a third of TAP assessors indicated they were "often" (20%, n=10) or "more often than not" (10%, n=5) consulted or directly involved in transition planning. This is a decrease compared to 2017 when more than a third of assessors indicated they were "often" (29%, n=15) or "more often than not" (8%, n=4) were involved or consulted during transition planning. The percent of assessors indicating they were consulted "rarely" increased from 21% in 2017 to 36% in 2018. Regional differences were noted. When asked how often a DPP worker consults them about a participant's readiness for reunification, half of assessors indicated they were consulted "often" (28%, n=14) or "more often than not" (8%, n=4). The percent of assessors indicating they were consulted "rarely" increased from 13% in 2017 to 34% in 2018. Assessors were also asked how often DPP workers consulted them about relapse prevention and safety planning. More than one-fourth (28%, n=14) of assessors reported DPP workers consult them about relapse prevention and safety planning "often," while 12% (n=6) reported being consulted "more often than not," and 38% (n=19) reported they were "sometimes" consulted. In 2018, 22% (n=11) of assessors reported they were "rarely" consulted about relapse prevention and safety planning. This is an increase compared to last year when 8% (n=4) of assessors reported "rarely" being consulted.

Final Assessor Comments

Large caseloads and frequent DPP worker turnover continued to be noted as primary concerns this year. However, assessors expressed appreciation for caseworkers' collaboration with TAP, noting their dedication and hard work under extremely difficult circumstances. Strengths and weaknesses were identified at the county level, indicating increased inconsistency statewide. High utilization of TAP services was noted in some counties while in others, TAP noted decreased referrals and collaboration due to turnover. Overall, assessors expressed hope that staffing stabilization, reduction in caseload size, combined with training and supervision, would lead to improvement.

Implications for Service Improvement

The results summarized above point to several opportunities to improve both DPP and TAP services. These include increased utilization of TAP during early stages of case development; increased overall utilization of TAP; increased TAP involvement in initial case planning conferences and Family Team Meetings; continued improvement in collaborative case planning; continued improvement in communication between DPP workers and TAP assessors; continued enhancement of DPP workers' understanding of major barriers for low-income parents; continued enhancement of DPP, judges, and other community partners' understanding of MAT; and continued improvement in DPP/TAP collaboration with regard to reunification readiness, transition planning, relapse prevention, and safety planning.

Continued collaboration between TAP and DCBS supervisors/staff, at local and regional levels, could be very beneficial in meeting needs and maximizing opportunities for service improvement. Regional data included in this study can help DPP and TAP to explore regional differences identified by survey participants, especially those related to the strengths, weaknesses, and unique characteristics of each part of the state. Through increased understanding of approaches and communication/collaboration strategies that have been effective in certain regions, a set of recommended practices could be used to meet the needs of other regions. Similarly, understanding practices in regions struggling with

communication and collaboration could enhance understanding of the barriers involved and identify new solutions. For example, protocols encouraging earlier referral and improved communication could be jointly developed in addition to trainings to enhance case planning. TAP assessors could provide in-house trainings on targeted barriers and the ways TAP services can help, perhaps during new worker orientation as well as throughout the year.

TAP assessors continue to compliment DPP workers for their efforts and remain aware of the demands and difficulties they face. Assessor concern about the adverse relationship between caseload size and casework quality continued this year. Assessors noted that some DPP workers go beyond their job requirements and possess exceptional case planning, communication, and collaboration skills. It may be helpful for DPP to identify these staff, as well as counties that excel in collaboration, to develop model practices. These model practices could then be used statewide, which could promote more consistent casework and services. Possible strategies are presented below.

Increase Earlier Referral to TAP

In 2019, TAP will continue to work with DPP to increase the percentage of referrals made in the investigation phase of a child welfare case. TAP currently receives referrals from DPP at any point in the life of the case. However, DPP and TAP have determined the TAP approach provides a resource that allows DPP to refer as early as possible and "front load" services for families. For some cases, TAP can assist parents in accessing appropriate services so children can remain safely in the home. For cases in which children have been removed due to abuse or neglect, TAP services can help reduce permanency timeframes. This can include return to home or determination that reasonable efforts have been made by DPP and termination of parental rights is warranted.

In 2019, TAP will continue to collaborate with DPP to increase the number of referrals made as early as possible. For example, in one large, urban county, TAP co-locates an assessor with the Investigation teams in Louisville, KY to improve collaboration with and consultation to DPP, encourage earlier initiation of TAP services, and increase frontloading services for vulnerable families. In a smaller rural county, TAP and DPP meet on a daily basis to discuss active investigations and possible services needed for families. TAP receives most referrals through this process. Another strategy DPP/TAP strategy involves investigation teams referring almost all cases to TAP for review so appropriate referrals can be identified early in the case. These strategies will continue in 2019 and will be introduced in TAP implementation meetings with regional management and local supervisors statewide as options to increase earlier referral and front-loading of services.

TAP will collaborate with the DPP and Family Court or District Court judges to initiate referral to TAP for assessment early in the case. With release and consent, TAP will facilitate communication with courts, DCBS, participants, lawyers, and guardian ad litems when applicable. This ensures earlier identification of barriers and recommendations for services, including additional evaluation when warranted to assist DCBS with more individualized case planning. This practice will also help ensure court ordered assessments are appropriate, non-duplicative, and use resources wisely. Collaborating with TAP is an engagement strategy that gives more parents the opportunity to take an active role in their case plans.

In meetings with DCBS regional staff, TAP supervisory staff will initiate discussions of these and other ways to increase earlier referrals to TAP. Strategies will include: a) TAP presentations to DPP investigation teams about program services and ways to refer; b) encouraging TAP participation in initial case planning conferences and Family Team meetings, where potential referrals could be identified and accepted; c) regional and county-level TAP implementation meetings with DPP management staff to

facilitate earlier referrals and to address systemic barriers; and d) use data to identify those counties or individual workers where referrals appear to be delayed and provide additional support to encourage earlier referrals.

Increase DPP Referral of In-Home Cases

In 2018, half (50%) of cases in which TAP was involved were out-of-home cases (i.e. children removed, with possibility of reunification), an increase compared to 46% in 2017. With Kentucky's implementation of FFPSA, DPP is encouraged to provide prevention services addressing mental health, substance use and parenting skills to keep at-risk children from entering the foster care system. In fiscal year 2019, TAP will encourage increased referral of in-home cases, increased collaboration with DCBS in the development of prevention plans, assisting parents in accessing substance use and mental health services, providing ongoing recovery supports, and working with other community partners to ensure a safe and nurturing environment so children may remain in the home.

Increase Participation in FTMs

In 2018, 41% of assessors reported they were involved in Family Team Meetings (FTMs) "more often than not" (23%) or "often" (18%), a slight decrease compared to 2017. TAP continues to collaborate with DPP on strategies to increase FTM invitations. For example, in Jefferson County, FTM facilitators copy TAP on emails scheduling facilitated FTMs so requests can be coordinated and one of the Jefferson County TAP assessors assigned. In those counties without FTM facilitators, TAP will discuss barriers and solutions to increased FTM involvement in regional TAP implementation meetings to explore protocols that could be developed to notify and invite TAP to participate in FTMs. In the Eastern Mountain DCBS Service Region, for example, regional management developed a system to incentivize TAP involvement in FTMs. In addition, TAP will initiate FTMs and case planning conferences when needed. The goal is to increase the percent of assessors invited to FTMs "more often than not" or "often" to 50% or above in 2019.

Increase Use of TAP Information

Although overall use of the information TAP provides to DPP has increased, improvement is needed, especially incorporating information in case plan formulation and reunification planning. TAP supervisors will initiate local discussions of ways to increase collaboration on the formulation of case plans so plans reflect individual differences and needs. Early referral to TAP and inclusion in initial case planning meetings would support this goal. In addition, the practice of holding post-assessment meetings with DPP referral source, participant, and assessor to discuss recommendations and action plan could be increased. Assessors noted the lack of TAP information in DPP's electronic case record (TWIST) and commented on the benefits to DPP if TAP were given access to TWIST to enter case-specific information. Currently, caseworkers must enter the information in the record, but time constraints prevent them from doing so. TAP has been informed there is no current way to provide access to assessors to enter information, so this remains an area for exploration. TAP will also discuss ways to increase consultation throughout the case, especially when planning reunification, and will encourage increased Family Team Meetings to discuss reunification. In 2018, TAP supervisors initiated local discussions of ways to increase DPP caseworkers' use of the information provided in TAP monthly reports on participant engagement, recommendations, and progress. As a result, in 2019, TAP will change the method of delivering monthly case status reports to DPP workers and supervisors to make the information more accessible.

Improve Individualized Case Planning

A common theme in the 2018 survey was the need for training on individualized case planning across all barriers, with assessors suggesting DPP workers would benefit from training on how to create a case plan that reflects and provides for individual differences and needs. For example, assessors suggested focusing on case planning with families with basic needs barriers due to poverty, especially transportation and housing, would be useful to DPP. Training to better equip DPP to do case planning and communicate with parents with cognitive deficits was also suggested. In addition, training on how to incorporate understanding of IPV and addiction into individualized case planning would be beneficial. TAP will provide consultation on incorporating TAP information in case plan formulation.

Continue MAT Training

Although progress is being made, given ongoing stigma, negative attitudes, and the continued limited understanding of MAT, there appears to be a need for continued training of DPP staff, judges, service providers, and other community members. Responses from the 2018 survey indicated the training provided to DPP staff has been helpful, and increased outreach to judges has resulted in improvement. With increased diversion leading to abuse of MAT drugs, this training should be designed to highlight the benefits of MAT, while also addressing concerns about treatment implementation and outcomes. TAP will continue to provide informal training about MAT through case consultation and will be available to provide formal training as requested. As noted previously, in 2019, the TAP OUD Project will be implemented in selected counties with high risks for opiate related deaths. Through this project, TAP will pilot increased collaboration and training opportunities with MAT providers and other treatment providers of services. TAP will also promote increased training opportunities through community partnerships such as Agency on Substance Abuse Policy (ASAP), UNITE, and community drug courts, as well as the Kentucky Opioid Response Effort and START.

Increase Service Access

With the implementation of the FFPSA in 2019, the TAP approach support frontloading of services for parents referred to the program. TAP is in a key position to provide an independent assessment and referral to appropriate care and assist participants in navigating systems. While behavioral health services have expanded in some areas of the state, treatment providers continue to change, especially for substance use disorder treatment. TAP staff will maintain current knowledge of available services and MCOs' coverage to educate participants and DPP staff and facilitate appropriate referrals.

Expand TAP Pre-Treatment Strategies

In response to gaps in services, TAP continues to explore ways to expand strategies to help participants meet their DPP case plan goals. For example, TAP has provided intimate partner violence and substance use pre-treatment education and treatment support for participants in both individual and group settings. Collaboration between the Nelson County TAP assessor and DPP supervisor led to identifying there were no accessible and affordable parenting classes, which was a primary barrier to families meeting their DPP case plan goals. TAP applied for and received a mini-grant from CCC to purchase the STEP parenting curriculum and classes were successfully provided. In 2019, TAP will explore the feasibility of providing parenting education tailored to the needs of parents with multiple barriers in other TAP counties.

At the request of one service region, TAP initiated a parenting screening pilot project in February 2018. Adapted from the Strengthening Families Model, the TAP Parental Protective Factors Screening Pilot Project is strength-based and focused on screening TAP participants for the following protective factors during assessment: parental resilience, social connections, concrete support for families, knowledge of parenting and child development, social and emotional competence of children/nurturing and

attachment. The pilot was conducted in four counties initially, and then expanded to additional counties during the year. TAP will expand this practice statewide in 2019. TAP will incorporate information related to protective factors screening in assessment summary reports, monthly case status reports, and will work with participants to strengthen parental protective factors through individualized plans.

The TAP Opiate Use Disorder project will co-locate 19 assessors and 3 field supervisors in DCBS offices in 14 high-risk counties. Referrals will come from DPP, the Division of Family Support, and other county/community partners. The target population will be low-income parents with/or at-risk for opioid use disorder and co-occurring disorders. Services provided by assessors will include intensive outreach with strengths-based engagement, comprehensive assessment, referral to MAT and other treatment services, pre-treatment, intensive case management, follow-up, and treatment support. Evidence-based approaches, including Motivational Interviewing and Strengths-Based Intensive Case Management will increase participant engagement, reduce barriers to treatment, and increase access to MAT and other community treatment services, as well as increase treatment retention. Assessors will provide pretreatment and ancillary services when needed. These services will include assistance with treatment payment, emergency and transitional housing, transportation, and childcare. In addition, assessors will provide, when requested, consultation and training to DCBS case managers and case workers to enhance professional skills related to OUD, increase effective, non-discriminatory responses to individuals with OUD, and increase county and community support for evidence-based OUD interventions and prevention efforts. In addition to serving participants through this TAP expansion, the project will assist TAP and DCBS in identifying strategies that can be implemented in all TAP counties.

<u>Provide Consultation and Training to Meet Identified Needs</u>
TAP will continue to be available to provide consultation and training to DCBS and other community partners when requested. TAP assessors provided presentations on TAP services to DCBS staff and community partners in their communities throughout the year. The most common participation barrier reported by DPP to training is lack of staff time due to large caseloads. Approaches to addressing this barrier include providing training during regular DPP staff meetings and through individual case consultation. TAP will continue to provide case consultation on both TAP and non-TAP cases. TAP will continue to work with DPP to increase the number of initial and periodic case planning conferences and Family Team Meetings to which TAP is invited during 2019. TAP will also increase initiation of post-assessment meetings with the caseworker and participant.

KK. Title IV-E Waiver Demonstration Project

The Title IV-E waiver demonstration project is awarded to states by HHS. HHS has the authority, through Section 1130 of the Social Security Act, to grant waivers to states that provide flexibility in spending Title IV-E funds to implement new approaches to prevent foster care placement and to improve outcomes for children if these proposals meet federal standards. Waiver demonstration projects do not provide additional funding to carry out new services; rather they allow for more flexible use of federal funds in order to test new approaches to service delivery and financing structures, in an effort to improve outcomes for children and families involved in the child welfare system.

The state is currently participating in a Title IV-E waiver demonstration project targeting substance abuse and family violence to prevent removal. As of October 2015, Jefferson START has expanded from one team to two teams and is serving families under the title IV-E waiver. Kenton County is also expanding from one team to two, and Fayette County began serving families in January 2017. Boyd

County also began serving families under the title IV-E waiver in July 2017. Daviess County began taking START cases under the waiver in July 2018.

In addition to START, the state has developed a new in-home services intervention. CHFS implemented Kentucky Strengthening Ties and Empowering Parents (KSTEP) as a resource to prevent unnecessary removals of children and to reduce the number of children in OOHC. KSTEP launched in July 2017 in Carter, Greenup, Mason, and Rowan Counties. KSTEP leadership has approved expansion for four additional counties in the Northeastern Service Region: Bath, Montgomery, Lewis, and Fleming. Through the waiver, KSTEP seeks to 1) reduce the need for OOHC placements; 2) shorten the duration of any necessary OOHC placement; 3) reduce repeat maltreatment, and 4) increase well-being of families by enhancing caregivers' capacity to care for children and maintain them safely in their own homes. To achieve the above goals, the KSTEP program integrates substance abuse treatment services, child welfare practice, and family preservation services into an approach to deliver services that address the special needs of substance-affected families involved with DCBS.

KSTEP launched in July 2017. As of March 19, 2019, there have been 207 referrals and 193 cases have been accepted between the four counties serving a total 371 children. Since the involvement of those families with KSTEP, 254 children have remained in their home, 13 were placed with relatives, and 3 were placed in OOHC. Since implementation in July 2017, KSTEP has experienced 36 unsuccessful closures and 76 successful closures. The KSTEP evaluation team is currently conducting a cost-benefit analysis to evaluate the effectiveness of the program, considering expenditures of the program and foster care costs saved by children remaining safely in their home.

KSTEP emphasizes collaboration between families, DCBS, non-profit behavioral health providers, and CMHCs to achieve positive outcomes. DCBS collaborates with non-profit behavioral health agencies to provide in-home services and with CMHCs to provide quick access to substance use disorder treatment. In-home providers, CMHCs, and DCBS staff have weekly contact with one other to discuss and provide updates on case progress. A KSTEP workgroup comprised of the contracted service providers, DCBS leadership, behavioral health representatives, and evaluation team members meet on a monthly basis. Direct line meetings, comprised of KSTEP leadership, regional leadership, KSTEP providers, and DCBS supervisors also meet on a monthly basis.

It is anticipated that the waiver will increase positive outcomes for children in their home, improve their safety and well-being, and prevent child abuse and neglect. Furthermore, it is expected that this will decrease entry and re-entry into foster care. Anticipated barriers include high staff turnover.

LL. Trauma-Informed Care

Trauma-informed care is an approach toward engaging providers, which recognizes the potential presence of trauma symptoms and the role that trauma may play in an individual's life. The approach seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?" Most consumers of behavioral health services have experienced at least one traumatic event in their lives. Programs and services related to trauma-informed care are offered at a statewide level for consultation and oversight assistance. Specific trainings are offered at a regional level, in an effort to train all direct care staff across the state.

One administrative program management staff with DCBS continues to be involved with the statewide steering committee on trauma-informed care. Quarterly meetings involve training and resource building surrounding trauma-informed practice. The steering committee consists of representatives

from the Department of Public Health, early childhood development, school systems, mental health professionals, correctional systems, medical professionals, disability rights advocates, sexual assault prevention advocates, and domestic assault prevention advocates. The committee allows for additional collaboration with community partners, as well as offers additional information gathering and distribution.

Several foster care providers throughout the state are working toward training therapists in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), which is a specific mode of cognitive behavioral therapy. TF-CBT has proven to be effective in helping participants learn new skills to help process thoughts and feelings related to traumatic life events; manage and resolve distressing thoughts, feelings, and behaviors related traumatic life events; and enhance safety, growth, parenting skills, and communication.

Currently, one psychiatric hospital in the state offers a 16-week program, where youth are patients of the hospital and have the ability to complete a standardized curriculum for TF-CBT. One of the challenges of this program is that although this program is set up to be at a lower level of care than an acute psychiatric admission, there is only an agreement with one of the five MCOs in the state to refer participants into this program, which provides the TF-CBT as well and a highly supportive environment. Although this inpatient/residential TF-CBT program is a needed service, unfortunately the two Medicaid MCOs with the largest numbers of members elect not to cover this service. This creates a barrier to accessing this service based solely upon the algorithm used to assign members to MCOs.

The University of Kentucky Center on Trauma and Children operates the Child and Adolescent Trauma Treatment and Training Institute (CATTTI Clinic http://www.uky.edu/CTAC/CATTTI). CATTTI provides in-depth trauma assessments and training for providers on how to best serve and treat children that have experienced traumatic events – including those that are clients of DCBS.

DCBS currently collaborates with private agencies that are working with trauma-informed curricula or milieu models. Two large private residential and foster care agencies are currently implementing the Risking Connections trauma-focused program (http://www.riskingconnection.com/rc_about.php). There are significant costs associated with implementation of this program, which continues to be a challenge both for the agencies that are currently using the program, as well as for those who would like to use this model in the future. Additionally, while the Risking Connections model works well, there are subgroups of child welfare clients that tend to have a poor response to Risking Connections.

KCADV has changed the training curriculum for all of their victim advocates working in shelters and non-residential sites. The new curriculum was developed by the National Center on Domestic Violence, Trauma, and Mental Health. Adopting a trauma-informed approach to domestic violence advocacy means attending to survivors' emotional and physical safety. Just as the advocates help survivors to increase their access to economic resources, physical safety, and legal protections, using a trauma-informed approach means that they also assist survivors in strengthening their own psychological capacities to deal with the multiple complex issues that they face in accessing safety, recovering from the traumatic effects of domestic violence and other lifetime abuse, and rebuilding their lives. It also means ensuring that all survivors of domestic violence have access to advocacy services in an environment that is inclusive, welcoming, de-stigmatizing, and that does not re-traumatize.

During the late part of 2015, staff from DCBS and a large agency in Eastern Kentucky, Ramey-Estep Home, which provides residential, substance abuse, and therapeutic foster care, traveled to Winchester,

Virginia to see the demonstration of the Ukeru System at the Grafton Health Care facility. Ukeru is a system of milieu management and client services that has the purpose of reducing use of seclusion and physical management, reducing injuries to staff, reducing agency costs and enhancing the treatment atmosphere. DCBS, DBHDID, and the Ramey-Estep Home previously investigated grant possibilities to implement Ukeru at the first agency in Kentucky. For more on Ukeru, see their website at http://www.ukerusystems.com/. As of the 2018 submission, although Ukeru has been explored, the considerable expense of training and implementation place it out of the reach of providers in Kentucky.

The state has encountered an interesting dynamic within the past few years related to access to "certified" trauma-informed care providers. There has been a handful (approximately five or less) of cases over the past two to three years where the courts have ordered DCBS to pay specific providers that are "certified" in trauma-informed care. There is the appearance that a certification – which takes time and financial investment – has been seen as the only appropriate way to deliver this service. Currently, there are very few "certified" trauma-informed treatment providers within the network of private foster care and residential treatment providers. Due to the expense and time commitment, the number is likely to remain low for the near future.

MM. Work Incentive Program

The work incentive program (WIN) is a work expense reimbursement program. Eligible recipients receive a monthly payment to cover any work-related expense for a period up to 9 months. WIN assists families transitioning off welfare by enabling the family to achieve or maintain self-sufficiency. WIN also promotes family stability, preventing OOHC placement of children. WIN is funded by Title IV-A. WIN is available statewide to eligible K-TAP recipients whose K-TAP case discontinues with earnings. Eligible WIN recipients may receive a work expense reimbursement payment for $130 for up to 9 months. Work expenses may include transportation costs, clothing necessary for work, or food. Receipt of WIN does not exclude individuals from receiving other benefits such as the Supplemental Nutrition Assistance Program (SNAP) or Medicaid. WIN was created as a result of a study conducted by Manpower Demonstration Research Corporation (MDRC). The findings of this study indicated income supports proved to be more effective than case management in helping individuals stay off welfare and remain self-sufficient.

To be eligible for WIN, the individual must be discontinued from K-TAP with earnings; be employed; have a work expense; have a child in the home; be a resident of Kentucky; and have total gross earned and unearned income at or below 200% of the federal poverty level. Individuals may only receive WIN once in a lifetime. Additionally, they may not waive receipt of WIN in order to receive WIN later. If the individual no longer meets WIN requirements or reapplies for K-TAP, WIN payments will stop even if months are remaining in the eligibility period. Effective November 2012, payments for WIN are generated from the Online Tracking Information System (OTIS). The first payment for WIN is automatically issued once a K-TAP case with earnings is discontinued. For the remaining months, the recipient receives a form to verify eligibility that must be completed and returned to the local office to continue to receive the WIN payment.

No changes in policy or practice have been made to the WIN program during calendar year 2018. From January 1, 2018 through December 31, 2018, an average of 354 WIN payments were issued per month for a total of $552,890.00.

NN. Y-NOW Children of Prisoners Mentoring Program (YMCA Safe Place Services)

YMCA Safe Place Services is a social service branch of YMCA of Greater Louisville. Beginning in 1974, YMCA Safe Place Services has touched the lives of thousands of teens and their families by providing emergency shelter, outreach, family mediation, and mentoring services. The mission of YMCA Safe Place Services is to accept, affirm, and advocate for teens and families in crisis through programs that empower youth to reach their full potential in spirit, mind, and body.

Y-NOW, the mentoring component of YMCA Safe Place Services, has been working with unique populations of youth since 1996, including both middle and high school students, Hurricane Katrina evacuees, youth who are at risk of dropping out, youth transitioning from eighth to ninth grade, and Children of Prisoners.

Y-NOW collaborates with the local school system (Jefferson County Public Schools), family and juvenile court, Neighborhood Place, CHFS, Seven Counties (now Centerstone), probation and parole, and other agencies involved with children of prisoners. The program service area is the Greater Louisville metro area.

Offered services are free of charge to the youth and family. Funding for the Y-NOW Children of Prisoners Mentoring program comes from Metro United Way, Louisville Metro Government, and other local organizations and individuals.

For the past 14 years, Y-NOW has worked almost exclusively with youth who have a parent incarcerated. The trauma to a child of having an incarcerated parent has been likened to experiencing the death of a loved one, but the grief that the child experiences often goes unnoticed and unacknowledged. It is common for them to exhibit anxiety, shame, fear, sadness, and guilt. In addition, these inward battles present themselves in anti-social behaviors that have resulted in an alarming profile: Children of incarcerated parents are at an increased risk of anxiety, depression, aggression, truancy, substance abuse, attention disorders, and poor scholastic performance. In fact, studies indicate that children of prisoners are more likely to become incarcerated themselves one day. Y-NOW's goal is to break that cycle.

<u>Outcomes</u>

- To increase the success of youth in school.
- To prevent or reduce the use of physical violence against others in the community, home, and school.
- To prevent or reduce the risk of delinquency and involvement in the court system(s).
- To improve family relationships (and support systems).

MUW Indicators/Outcomes	**NEW MATCHES IN 2018**	**SUSTAINED MATCHES**
75% demonstrate an improvement in school performance (grades, suspensions, attendance)	87%	80%
85% report improvement in family relationship (Stability, communication, no runaways, etc.)	90%	90%
75% have no new arrest and/or out of control behavior	96%	90%
75% will not initiate any (or any new) contact with family/juvenile court	96%	90%
80% pass to the next grade	98%	90%

MUW Indicators/Outcomes	2017/2018 SPRING CLASS AND 2018/2018 FALL CLASS	ALL Y-NOW PARTICIPANTS (2004-2018)
% Achieve Academic Success (Improvement)	87%	---
% Pass to Next Grade	98%	---
% Missing Less than 10 days of school	85%	---
# Graduated Middle School	---	246
# Graduated High School and/or Earn GED	---	154
# Currently enrolled in Elementary/Middle/High School	---	128
# Enrolled in 2 or 4 year college or Technical School, or in Armed Forces	---	---*
# Graduated 2 or 4 year college or Technical School, or completed Armed Forces commitment	---	---*
**Due to limitations with tracking and access to youth data, the program does not have the capacity to track youth past high school.*		

Volunteer Recruitment and Training

Following the evaluation of volunteer trainings, the trainings were adjusted and the curriculum was revised. There is now a full Saturday volunteer training for mentors (retreat volunteers attend the first half of the day) instead of two half-day trainings. This prevents mentors from spending two entire weekends with Y-NOW (training weekend and retreat), especially since weekends are within two weeks of each other. Youth enrollment training now occurs before each session. The volunteer recruitment specialist goes over what paperwork the volunteers will help the youth with while the director meets with the youth about the program and what they are about to sign up for. Both of these adjustments have yielded positive feedback from volunteers, as well as reduced expenses for food during trainings and reduced staff requirements for weekend and evening events.

In 2018, the program revised retreat volunteer positions and added a partial retreat volunteer option. Instead of staying the entire retreat weekend, partial retreat volunteers attend the retreat from Friday morning until after lunch on Saturday. Many mentors arrive to the retreat on Saturday morning, so partial retreat volunteers fill the void of missing adults and then are able to leave (and make room for mentors, as space is limited in the course room at the retreat) Saturday around lunch. This volunteer option has increased volunteer participation at the retreat.

Youth Referrals and Youth Enrollment

Youth referrals primarily come from area school counselors, therapists, and families. While the program accepts referrals all year long, the youth recruitment and enrollment process picks up two months prior to each retreat kickoff (February through March for the spring cohort and August through September for the fall cohort). Phone calls are made to youth who met the requirements of the program and expressed an interest in joining the community. Four youth enrollment sessions are held per cohort, during which volunteers assist youth in completing their five-page application. Volunteers also work with each youth to finalize both their personal and educational goals for the year.

Caregivers, Guardians, and Parents

In 2018, the program changed the way youth enrollment occurs. Instead of requiring caregivers to attend a youth enrollment session at Safe Place in order to enroll their child in the program, the program started scheduling and conducting individual caregiver meetings. These meetings are completely centered on the caregiver's availability and needs; meetings are typically conducted with the case manager at either Safe Place or the family's home. Meeting with the caregiver individually allows the case manager to explain the program and paperwork in detail, answer any questions the caregiver may have, and establish a relationship between the caregiver and case manager, which has been very beneficial for the program. (Youth still come in for shorter youth enrollment sessions to complete paperwork and meet other youth who will be in the program with them.) The current spring and fall classes are the first classes with the new youth enrollment approach, and so far, the new approach has produced stronger caregiver-staff relationships and more caregiver buy-in to the program. Almost all youth have a family member represented at family days and case managers are having more success checking in and communicating with caregivers.

Case managers continue to conduct monthly phone calls with caregivers throughout the follow-through program and provide additional support and resources as needed to caregivers, youth, and families. Caregivers are invited to two family days during the 10-month program, as well as the gradation celebration at the end of the program.

Youth and Mentor Retreat

To prepare for retreat, volunteers (5-10 people) donate a few hours to help staff load and unload two vans full of equipment, materials, and supplies to the retreat site. Volunteers also help staff set up and prepare the course room where all group meetings will be held. This site set up occurs the day before each retreat. On the day of each retreat, 5-10 departure volunteers help staff check youth in for the retreat by collecting medications, signing youth in, searching bags, etc. After all youth are checked in and have read a commitment statement in front of the group, the retreat and partial retreat volunteers (15-20 volunteers) accompany a busload of 25-30 youth and staff to Country Lake Christian Retreat in Underwood, Indiana. A 3-day retreat takes place with the youth and volunteers/mentors to kick off the program. It includes a variety of guided group conversations and experiential activities designed to have the youth take a look at what is getting in the way of them being successful and begin to develop an action plan for their future (particularly around their education). A fair amount of time is spent building trust and creating a safe and supportive community so that the youth can begin to talk about what it is like to have an Incarcerated parent. The youth also complete a high ropes course. Mentors usually join the group at the retreat Saturday morning and staff for the rest of the weekend. Youth are paired with their mentor Saturday night of the retreat during a special ceremony.

One-to-One Mentoring Match

Each youth receives a weekly phone call and face-to-face visit from a thoroughly screened and trained volunteer mentor. The volunteer mentor contacts the youth to show support and discuss progress made towards goals.

10-Month Follow-Through Program

Group meetings take place twice per month and are designed to address specific topics of interest for the youth population (e.g. trust, responsibility, diversity, integrity, anger management, communication, peer pressure, human sexuality, and responsible sexual behavior). The youth and their mentors also plan a community service project and lock-in. Throughout the year, Y-NOW case management staff and mentors work closely with the schools to monitor performance. Y-NOW staff also monitor involvement

with other community agencies (e.g. juvenile/family court, drug assessment, truancy diversion) to ensure the full scope of youth needs are met.

Sustained Relationships/Youth Leaders

Upon graduation, youth have the opportunity to continue participation on two levels. First, Y-NOW offers alumni gatherings/reunions annually for the youth and mentors to come back together and catch up. Many youth and mentors continue to work together once they have graduated, and Y-NOW provides any ongoing support needed. Second, those youths who take part in training and meet criteria have the opportunity to serve as a youth leader for the next program.

Key Accomplishments

1996:

- Project New Outlook Within (NOW) launched as a result of Louisville citizens advocating for this effective program.
- The first residential course at YMCA Camp Piomingo took place with youth referred from Jefferson County Courts, Jefferson County Public Schools, and the Housing Authority.
- WHAS-TV film crew won an Emmy for their documentary of the residential camp.

1997:

- Kentucky's DJJ is awarded Project NOW $100,000 for 2 years.

1999:

- Funding was received from the Community Juvenile Justice Partnership Grant.

2000:

- Mental Health Association of Kentucky awarded the program the Phillip P. Ardery Youth Second Chances Award.

2002:

- The program received a $220,000 federal grant from the Office of Juvenile Justice and Delinquency Prevention (JUMP). Project NOW was one of 66 recipients (out of 863 applicants) to receive the grant and the only recipient in Kentucky.
- Program offices and activities were moved from Berry Boulevard to the new Crittenden Drive facility.

2003:

- The first contracted program was established: an independent living program for CHFS, which served ten 16- through 19-year-old youth.
- Camp Loucon was used for the first time.

2004:

- The Y-NOW logo and theme were developed.
- Y-NOW received a 3-year $157,000 grant from HHS to begin a Children of Prisoners Mentoring Program. As one of 52 programs funded in the pilot year, Y-NOW was the only chosen program in Kentucky.
- Valerie Steinlander (a long-time Y-NOW volunteer) was awarded a Bell Award from WLKY-TV.

2005:

- A contestant on *The Apprentice* was the keynote speaker at the Y-NOW Children of Prisoners graduation ceremony, courtesy of Y-NOW's corporate sponsor, JP Morgan Chase Bank.
- The youth leader training program began for past youth graduates to assist in the

facilitation of the residential and aftercare phase for the new groups.

- A 4-year volunteer in the Y-NOW program was named a YMCA Outstanding Volunteer.
- A mentor of the Y-NOW Children of Prisoners program was awarded the "Building Strong Families" award from Metro United Way.
- In acknowledgement of success with the Y-NOW Children of Prisoners program, HHS awarded Y-NOW a one-time grant of $50,000 to work with Hurricane Katrina evacuees in Louisville.
- The director facilitated a Hurricane Katrina workshop.

2006:

- Y-NOW scored a perfect 100 and is awarded a 3-year $225,000 grant from HHS to continue working with children of prisoners through 2010.
- Hurricane Katrina youth, families, and mentors traveled to New Orleans, supported by the Crusade for Children and with WHAS-TV riding along and filming.
- Two volunteers were acknowledged as YMCA Outstanding Volunteers.
- WHAS-TV re-visited for a look at the evolution of the Y-NOW program and the success and challenges for Children of Prisoners.
- The director co-facilitated a Children of Prisoners camp.

2007:

- Efforts began to maintain/sustain relationships with past Children of Prisoners.
- Y-NOW was one of three programs across the country interviewed for a special Nick News feature on children with an incarcerated parent.
- Y-NOW staff facilitated camp without any consultants.
- Two mentors were honored as a YMCA Outstanding Volunteers.
- Two past youth participants and current youth leaders were awarded two of four inaugural Character Awards from the YMCA of Greater Louisville.

2008:

- A volunteer was honored as a YMCA Outstanding Volunteer.
- Y-NOW received the first referral from an incarcerated parent.
- A former Children of Prisoners youth (and youth leader) stepped up for the 2008/2009 program to serve as the logistics/production manager at camp.
- Two volunteers appeared in a YMCA spirit video talking about their volunteer experience with Y-NOW.
- Y-NOW was one of four Mentoring Children of Prisoners programs across the country asked to submit a story for publication to HHS on one successful match. Y-NOW was also asked to go through a security clearing process for a possible meeting with White House staff. Unfortunately, this meeting never materialized.

2009:

- A new program video and radio spot was produced.
- A volunteer was recognized as a YMCA Outstanding Volunteer.
- A former Project NOW youth became a Y-NOW mentor.
- A former Project NOW youth served as a camp volunteer.
- Y-NOW mentoring services created the Facebook "Fan Page."
- More than 105 youth were now in "sustained relationship."
- HHS rewarded Y-NOW a 3-year grant that afforded 3 more years of Children of Prisoners funding.
- A youth in the 2008/2009 program was honored with a Youth Achievement Award from YMCA Safe Place Services.

- The director was a featured speaker at National Association for Children of Incarcerated Parents Symposium, Victory Over Violence, and the Kentuckiana Regional Planning and Development Agency's Grandparents Raising Grandchildren.

2010:

- A volunteer was recognized as a YMCA Outstanding Volunteer.
- Y-NOW mentoring services Facebook page had more than 160 fans.
- One hundred twenty-six youth were now in "sustained relationship."
- Y-NOW video was shown at the opening ceremony/breakfast of the National Mentoring Children of Prisoners Conference in New Orleans.
- Former Y-NOW Children of Prisoners youth won a full scholarship to University of Louisville's Speed School.
- Y-NOW completed a community service project (art murals) at a local halfway house while working with inmates and parolees.
- WHAS-TV completed a feature of Y-NOW's meeting of inmates/parolees at a halfway house.
- Director and staff appeared on WFPL (local national public radio station) to discuss Y-NOW program.
- Director appeared on "Senior Savvy" to discuss Y-NOW.
- The 2010/2011 program went to the street-level to find youth, prompted by the fact that more than five of the 28 youth participants were living in homeless shelters.

2011:

- A volunteer was recognized as a YMCA Outstanding Volunteer.
- A mentor was nominated for a HHS Outstanding Mentor Award.
- Y-NOW mentoring services Facebook page had more than 225 fans.
- One hundred and thirty youth are now in "sustained relationship."
- Sixteen "sustained" Y-NOW Children of Prisoners youth were in college; an additional 10 were headed to college in the fall of 2011.
- Director conducted a training for Grandparents Raising Grandchildren (KIPDA) and Camp Loucon staff/counselors on working with high-risk youth.
- Y-NOW youth raised over $3,500 towards a youth trip in July 2011 (a record amount fundraised).
- Program reduced due to federal budget cuts (HHS cuts Mentoring Children of Prisoners funding).

2012:

- Y-NOW alumni and members of Iota Theta Fraternity at University of Louisville participated in several events at Safe Place.
- The 2012 Miss America speaks at Safe Place Together 4Teens Fundraising Breakfast.
- Eight volunteers became participation managers, or "Honey Bees," and were later recognized as YMCA Outstanding Volunteers.
- A youth volunteer was awarded a YMCA Character Award and full scholarship to the University of Louisville.
- Director was a featured speaker at Victory Over Violence.
- *Frontline* documentary completed and The Public Broadcasting Service attended Y-NOW meeting as work began on a documentary regarding mass incarceration.

2013:

- Y-NOW Facebook's page had 265 likes, including a number of caregivers.
- The football coach and football players from the University of Louisville spent an evening

at Safe Place discussing overcoming adversity.

- Y-NOW conducted a pilot program at Kenwood Elementary School for Children of Prisoners.
- Two youth volunteers were nominated for YMCA character awards.

2014:

- Y-NOW's first alumni graduated from college with a bachelor's degree.
- Eleven-year-old is speaker at Together 4Teens Breakfast.
- Completed a 2-day workshop for Kenwood Elementary School and Field Elementary School for Children of Prisoners.
- Hired a new outreach specialist who was responsible for volunteer recruitment for Y-NOW.

2015:

- Six mentors were hired as new full-time volunteer case managers.
- Eighteen-year-old volunteer is honored as YMCA Volunteer of the Year.
- Fourteen-year-old is featured speaker at YMCA Safe Place Services Together 4Teens Breakfast.
- YMCA of Greater Louisville produced 30-second TV spot on Y-NOW Children of Prisoners Mentoring Program.
- Y-NOW hired a part-time volunteer coordinator.
- YMCA Safe Place Services committed to launching a second Y-NOW class annually beginning in 2016.
- Y-NOW Facebook page had 476 likes (fans).
- More than 250 youth participated in the Y-NOW Children of Prisoners Mentoring Program and 83% of youth on track to graduate successfully graduated high school or received their GED. More than 50 youth were in college, vocational school, or the armed forces.

2016:

- Y-NOW part-time volunteer coordinator became full-time as a volunteer recruitment specialist.
- Thirteen-year-old is featured speaker at YMCA Safe Place Services Together 4Teens Breakfast.
- Y-NOW case manager was hired in preparation for the launching of a second Y-NOW class.
- The extended leave of absence and ultimate separation of the long-time program director of YMCA Safe Place Services resulted in decreased engagement with sustained matches /alumni and delay in launching the second Y-NOW class.
- Two hundred ninety-nine youth participated in the Y-NOW Children of Prisoners Mentoring Program, and 87% of youth on track to graduate successfully graduated high school or received their GED.

2017:

- Sixteen-year-old youth leader was the featured speaker at YMCA Safe Place Services Together 4Teens Breakfast.
- A second class of Y-NOW was added in the spring of 2017.
- The case manager resigned in June, requiring the director to step in and manage the spring 2017/2018 class of Y-NOW.
- In the end of November, Y-NOW was able to reach full employment.
- Two hundred ninety-nine youth completed the 3-day retreat. Of the 299 youth, 269 youth completed the 12- or 10-month follow-through program. Eighty-eight percent of youth of on track to graduate successfully graduated high school or received their GED.

2018:

- The inaugural spring class graduated in January 2018 with 23 youth.
- A 14-year-old youth leader is a featured speaker as YMCA Safe Place Services Together for Teens Breakfast.
- The director retired; a fall case manager was promoted to director and new fall case manager was hired.
- To date, 387 youth have completed the 3-day retreat. Of the 387 youth, 331 youth completed the 12- or 10-month follow-through program.
- A youth leader was nominated and won a Youth Character Award, which includes scholarship money for college.